ISPA
INSTITUTO UNIVERSITÁRIO
CIÊNCIAS PSICOLÓGICAS, SOCIAIS E DA VIDA

DIALECTOS DA DOR:
REPRESENTAÇÕES SOCIAIS SOBRE AS FUNÇÕES DOS COMPORTAMENTOS AUTO-LESIVOS EM ADOLESCENTES

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Tese submetida como requisito parcial para obtenção do grau de

Doutoramento em Psicologia
Área de Especialidade . . . . . Psicologia Clínica

2018

Tese apresentada para cumprimento dos requisitos necessários à obtenção do grau de Doutor em Psicologia na área de especialização de Psicologia Clínica, realizada sob a orientação da Professora Doutora Maria Gouveia-Pereira e co-orientação do Professor Doutor Daniel Sampaio, apresentada no ISPA - Instituto Universitário, no ano de 2018.

AGRADECIMENTOS

À Professora Doutora Maria Gouveia Pereira, por todo o acompanhamento, orientação, esclarecimento de dúvidas e persistência em algumas sugestões.

Ao Professor Doutor Daniel Sampaio, pela orientação e inspiração.

Ao Hugo Gomes, pela preciosa colaboração e telefonemas tardios.

A todos os que fazem parte desta tese através do seu contributo – realização de entrevistas, preenchimento de questionários, aconselhamento estatístico, criação de contactos e apresentações, passa-palavra, reuniões, discussão de ideias, e muitos outros pormenores.

À Maria Duarte, pelo infindável apoio, paciência e compreensão. “O artista é um bom artista e não havia necessidade”.

Ao Rogério Hortêncio. “124C41+”

À Adélia Fatal, Ana Moniz e Paula Soares, pelas tertúlias e mojitos.

Ao pessoal do cosplay, por partilhar comigo tantos mundos tão diferentes.

Ao M. D. Luffy, por tudo o que representa e por nunca deixar ninguém para trás.

Palavras-chave:

Comportamentos Auto-Lesivos; Funções dos Comportamentos Auto-Lesivos; Representações Sociais; Adolescentes; Pais.

Key words:

Deliberate Self-Harm; Functions of Deliberate Self-Harm; Social Representations; Adolescents; Parents.

Categorias de Classificação da Tese:

PsycINFO Classification Categories and Codes:

2200 Psychometrics & Statistics & Methodology

2220 Tests & Testing

3200 Psychological & Physical Disorders

3210 Psychological Disorders

RESUMO

Os comportamentos auto-lesivos são actualmente considerados um problema de saúde pública, especialmente em adolescentes e jovens adultos. Tem existido um crescente foco investigacional nesta área e tem-se vindo a reconhecer a importância da esfera interpessoal, particularmente em termos de prevenção e intervenção. Contudo, são escassas as investigações que abordem as representações sociais sobre as funções destes comportamentos, nomeadamente no âmbito familiar e do grupo de pares. De igual modo, são poucos os instrumentos relativos a comportamentos auto-lesivos validados para Portugal que possibilitem o estudo destes comportamentos e das suas representações sociais.

O primeiro artigo consiste na adaptação e validação para adolescentes Portugueses da primeira secção do *Inventory of Statements About Self-Injury* (Klonsky & Glenn, 2009). A análise das qualidades psicométricas e da estrutura factorial deste instrumento revelou boa consistência interna e uma organização dos métodos auto-lesivos em três factores (Comportamentos Auto-Lesivos Severos e Tentativas de Suicídio; Comportamentos Auto-Lesivos Leves/Moderados; e Consumo de Substâncias Psicoactivas). Assim, este inventário demonstrou ser um bom recurso para o estudo da frequência dos comportamentos auto-lesivos e dos métodos utilizados.

No segundo artigo apresentamos uma análise qualitativa de várias entrevistas, que teve como objectivo a descrição e comparação das representações sociais sobre as funções dos comportamentos auto-lesivos de três grupos: adolescentes com uma história destes comportamentos, adolescentes sem uma história destes comportamentos e adultos igualmente sem uma história destes comportamentos. Os participantes referenciaram oito funções que vão ao encontro das descritas na literatura (e.g. Klonsky, 2007b) e duas novas funções. Foram também encontradas diferenças entre os grupos, nomeadamente que os adultos enfatizaram as funções interpessoais e que ambos os grupo de adolescentes mencionaram mais funções intrapessoais.

Os artigos três e quatro apresentam a construção e validação de dois questionários para o estudo das representações sociais sobre as funções dos comportamentos auto-lesivos, para adolescentes (Artigo 3) e para adultos (Artigo 4). Estes instrumentos foram desenvolvidos com base na segunda secção do *Inventory of Statements About Self-Injury* (Klonsky & Glenn, 2009), na análise anteriormente mencionada de entrevistas, e na análise de uma amostra da imprensa escrita generalista Portuguesa. Ambos os questionários demonstraram boas

qualidades psicométricas em termos de consistência interna e de estrutura factorial, possibilitando a sua utilização em estudos posteriores.

O dois últimos artigos (artigo 5 e artigo 6) tiveram como objectivo a exploração e comparação das representações sociais sobre as funções dos comportamentos auto-lesivos de adolescentes com e sem estes comportamentos e de pais. Os instrumentos utilizados nestes estudos consistiram no Inventário de Comportamentos Auto-Lesivos (ICAL), no Questionário das Representações sobre as Funções dos Comportamentos Auto-Lesivos para Adolescentes (QRFCAL-Adolescentes) e no Questionário das Representações sobre as Funções dos Comportamentos Auto-Lesivos para Adultos (QRFCAL-Adultos), previamente validados.

O artigo 5 focou-se na comparação entre as representações sociais de adolescentes com e sem comportamentos auto-lesivos, e na comparação das representações sociais de mães e pais de adolescentes com e sem comportamentos auto-lesivos. Em termos gerais, os resultados obtidos revelaram que os adolescentes sem comportamentos auto-lesivos atribuíram mais relevância às funções interpessoais e que os adolescentes com comportamentos valorizaram algumas funções intrapessoais. Por acréscimo, os pais de adolescentes com e sem estes comportamentos apresentaram algumas diferenças entre as suas representações sociais, especialmente no sentido em que as mães de adolescentes com comportamentos auto-lesivos enfatizaram algumas funções intrapessoais.

O artigo 6 baseou-se na comparação das representações sociais sobre as funções de comportamentos auto-lesivos em famílias (filho/a, mãe e pai) de adolescentes com e sem estes comportamentos. A partir da análise destes resultados surgiram diferenças consideráveis entre ambos os grupos de adolescentes e os respectivos pais, principalmente no sentido em que os pais enfatizaram as funções interpessoais e desvalorizaram as funções intrapessoais. Estas diferenças acentuaram-se nas famílias de adolescentes com comportamentos auto-lesivos.

ABSTRACT

Deliberate self-harm is nowadays considered a public health problem, especially in adolescents and young adults. Research has increasingly focused on this area and the relevance of the interpersonal context has been recognized, particularly in terms of prevention and clinical intervention. However, there are few investigations based on the study of the social representations concerning the functions of these behaviours, namely on the familiar and peer settings. Likewise, there are few instruments validated to Portugal that allow the study of deliberate self-harm and its social representations.

The first article is based on the adaptation and validation for Portuguese adolescents of the first section of the Inventory of Statements About Self-Injury (Klonsky & Glenn, 2009). The analysis of the psychometric properties and of the factorial structure of this instrument revealed good internal consistency and a structure of three factors (Severe Deliberate Self-Harm and Suicide Attempts; Mild/Moderate Deliberate Self-Harm; and Consumption of Psychoactive Substances). Therefore, this instrument demonstrated to be a good resource for the study of deliberate self-harm frequency and the methods used in these behaviours.

In the second article, we present a qualitative analysis of several interviews. This analysis had the objective of describing and comparing the social representations about the functions of deliberate self-harm from three groups: adolescents with a history of these behaviours, adolescents without a history of these behaviours, and adults also without a history of these behaviours. The participants mentioned eight functions that are in accordance with those described in the literature (e.g. Klonsky, 2007b) and two new functions. We also found differences between the groups, namely that adults emphasized interpersonal functions and that both groups of adolescents cited more intrapersonal functions.

Articles three and four present the development and validation of two questionnaires to study the social representations about the functions of deliberate self-harm, one for adolescents (Article 3) and one for adults (Article 4). These instruments were based on the second section of the Inventory of Statements About Self-Injury (Klonsky & Glenn, 2009), on the aforementioned analysis of interviews and on the analysis of a sample of Portuguese written press. Both questionnaires revealed good psychometric properties regarding internal consistency and factorial structure, allowing its further use.

The last two articles had the objective of exploring and comparing the social representations about the functions of deliberate self-harm from adolescents with and without

these behaviours and from parents. The instruments used in these studies consisted of the Inventory of Deliberate Self-Harm Behaviours (*Inventário de Comportamentos Auto-Lesivos*, ICAL), the Questionnaire of Representations about the Functions of Deliberate Self-Harm for Adolescents (Questionário das Representações sobre as Funções dos Comportamentos Auto-Lesivos para Adolescentes, QRFCAL-Adolescentes) and the Questionnaire of Representations about the Functions of Deliberate Self-Harm for Adults (Questionário das Representações sobre as Funções dos Comportamentos Auto-Lesivos para Adultos, QRFCAL-Adultos), previously validated.

Article 5 focused on the comparison between the social representations of adolescents with and without deliberate self-harm and on the comparison of the social representations from parents (mothers and fathers) of adolescents with and without deliberate self-harm. Globally, results showed that adolescents without deliberate self-harm gave more relevance to interpersonal functions and that adolescents with a history of these behaviours valued some intrapersonal functions. In addition, the parents of adolescents with and without these behaviours showed some differences between their social representations, since mothers of adolescents with deliberate self-harm emphasized some intrapersonal functions.

Article 6 was based on the comparison of the social representations about the functions of deliberate self-harm in families (adolescent, mother and father) of adolescents with and without these behaviours. Results revealed considerable differences between both groups of adolescents and their parents, mostly because parents emphasized interpersonal functions and devalued intrapersonal functions. These differences were accentuated in the families of adolescents with deliberate self-harm.

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Social Representations about the Functions of Deliberate Self-Harm: Adolescents and Parents

How do Families Represent the Functions of Deliberate Self-Harm?: A Comparison Between the Social Representations of Adolescents and Their Parents

Secção I

Introdução

Capítulo I. Comportamentos Auto-Lesivos na Adolescência

When you are in the grip of a love affair with a razor blade,
you exist in a parallel universe.
There is a rift, a void, between you and those close to you.
For them, black is black, and cutting is bad.
For you, white is black, and cutting is your salvation.
(Underman, 2005)

Uma das primeiras referências históricas a comportamentos auto-lesivos pode ser encontrada num relato de Heródoto que data do século V a.C., onde é descrito o episódio de um líder espartano que se auto-mutilou intencionalmente com uma faca (Clark & Henslin, 2007). Ao longo da história continuaram a surgir diversos relatos de práticas auto-lesivas, nomeadamente em rituais que utilizavam a auto-lesão como uma experiência ligada à cura, à espiritualidade e à manutenção da ordem social num determinado grupo. Neste sentido, os comportamentos auto-lesivos eram usualmente uma componente integrante de contextos de índole espiritual e religiosa, como ritos iniciáticos e outras práticas presentes em diversas culturas (Favazza, 1987).

Embora existam vários antecedentes históricos e culturais que poderão contribuir para a contextualização destas práticas, este fenómeno foi-se distanciando do seu anterior âmbito religioso e espiritual e assumiu novos contornos. Para além da sua prevalência ter aumentado (e.g. Morgan et al., 2017), as actuais características comportamentais destes actos apontam para a existência de uma nova fenomenologia clínica e psicológica, em que os comportamentos auto-lesivos são vistos como uma expressão de sofrimento (McAndrew & Warne, 2005). Certos autores (e.g. Conterio & Lader, 1998) destacam alguns factores sócio-culturais que poderão ter contribuído para o aumento da prevalência deste fenómeno. Entre estes encontra-se o facto da cultura Ocidental enfatizar as "soluções rápidas" e a gratificação imediata; o seu direccionamento social para o culto do corpo e para a crescente importância da aparência e apresentação física; e o facto da mudança estrutural das famílias tradicionais propiciar o aumento do isolamento dos seus elementos (especialmente das crianças e adolescentes).

Actualmente, os comportamentos auto-lesivos são considerados um problema de saúde pública, afectando particularmente adolescentes e jovens adultos (e.g. Hawton, Saunders & O'Connor, 2012; Klonsky & Olino, 2008), e são usualmente enquadrados no espectro dos

comportamentos suicidários. Com o aumento da prevalência destes comportamentos e a crescente visibilidade nos meios de comunicação social, o conhecimento das representações existentes sobre este fenómeno tem demonstrado ser relevante para a intervenção e prevenção dos mesmos (Bresin, Sand & Gordon, 2013). Assim, o foco desta tese incidirá nas funções dos comportamentos auto-lesivos e nas representações sobre as mesmas, tanto por parte de adolescentes que apresentem estes comportamentos, como por parte de adolescentes e adultos que não tenham uma história de comportamentos auto-lesivos.

Adolescência, Comportamentos Suicidários e Comportamentos Auto-Lesivos

A adolescência é uma fase do desenvolvimento determinante para a constituição de cada sujeito enquanto ser autónomo, seguro de si e da sua identidade. Simultaneamente, é durante a adolescência que surgem os mais variados desafios e conflitos intrapessoais e interpessoais, tornando-se por isso um momento propício para o aparecimento de comportamentos de risco, nomeadamente comportamentos suicidários.

Consoante Sampaio (1991), a adolescência consiste numa etapa que ocorre desde a puberdade até à idade adulta, ou seja, desde a altura em que determinadas alterações psicobiológicas iniciam a maturação até à idade em que um sistema de valores e crenças se enquadra numa identidade estabelecida. Existem diversas descobertas e desafios que alteram o adolescente e contribuem para o seu desenvolvimento, embora a adolescência se caracterize também por algumas tarefas essenciais. Tal como diversos autores sumarizam (e.g. Laufer, 2000; Sampaio, 1991), existem três núcleos centrais de tarefas que devem ser reanalisados durante esta fase da vida. O primeiro consiste na alteração da relação com as figuras parentais, passando pelo abandono de uma posição de dependência quanto às mesmas e pela criação progressiva de autonomia face à família. Em segundo lugar, deve ocorrer uma alteração da relação com o grupo de pares, em que este tenderá a assumir uma grande importância no âmbito do desenvolvimento emotivo e social do adolescente. Por último, a formação da identidade sexual deverá implicar a passagem por um conjunto de tarefas específicas que terão lugar na fase final da adolescência.

De acordo com a Organização Mundial de Saúde (WHO, 1986), existem três factores que marcam o final da adolescência e a transição para a adultícia. Estes pontos incluem o desenvolvimento biológico desde o início da puberdade até à maturidade sexual e reprodutiva, o desenvolvimento psicológico desde os padrões cognitivos e emocionais da infância até aos esperados na adultícia, e a passagem de um estado infantil de completa dependência sócio-

económica até à relativa independência. No entanto, devido a diversas alterações sociais, económicas e culturais, há autores que defendem a existência de uma fase entre a adolescência e adultícia (desde os 18 aos 25 anos), designada por adultez emergente (e.g. Arnett, 2000), que implicará tarefas específicas (e.g. Keniston, 1971).

A passagem por este conjunto de tarefas, o surgimento de novas possibilidades cognitivas e a negociação entre graus oscilantes de independência, responsabilidade, sentido de identidade e sentimentos/comportamentos sexuais (Judge & Billick, 2004) implicam a superação de diversas crises psicológicas. Estas crises podem ser consideradas como uma zona de turbulência em que se impõe uma renegociação das finalidades individuais e do conjunto do sistema (Sampaio, 1991) e são parte integrante da adolescência. Assim, estas frequentes discrepâncias processuais tornam os jovens particularmente vulneráveis a períodos de forte dor psicológica e desespero (Judge & Billick, 2004). No entanto, e apesar desta instabilidade psicológica e emocional poder ser considerada normal, existem igualmente adolescências patológicas. Estas traduzem-se essencialmente pela falta de esperanca e incapacidade para conseguir um sentido para lidar com as emoções, para organizar um sentido de pertença e para manter um sentimento sustentado de bem-estar (Guerreiro & Sampaio, 2013; Sampaio, 2006).

Para além desta instabilidade psicológica, os comportamentos de risco (i.e. consumo de álcool e outras substâncias psicoactivas, tabagismo, ou relações sexuais desprotegidas) são também comuns na adolescência e, até certo ponto, constituem comportamentos de experimentação normais nesta fase de desenvolvimento (e.g. Degenhardt et al., 2008; Levitt, Selman & Richmond, 1991; Matos et al., 2012; Zappe & Dell'Aglio, 2016). No entanto, tal como Guerreiro e Sampaio (2013) sublinham, mesmo que correr alguns riscos faça parte do desenvolvimento normal na adolescência, importa também considerar a possibilidade da fixacão do jovem a um padrão de consequências negativas que afectará o seu desenvolvimento.

Neste âmbito, os comportamentos suicidários na adolescência podem ser enquadrados simultaneamente nos comportamentos de risco e num possível padrão patológico da adolescência. Este fenómeno tem despoletado preocupação em vários países Ocidentais nas últimas décadas, principalmente desde que se verificou um aumento das taxas de suicídio de forma dramática nos anos 80 (Beautrais, 2002) e é hoje em dia perspectivado como um problema de saúde pública (e.g. Hawton et al., 2012; Nock, Borges, Bromet, Cha, Kessler & Lee, 2008; Pelkonen & Marttunen, 2003). O suicídio é a segunda causa de morte na

adolescência (Hawton et al., 2012), particularmente na faixa etária dos 15 aos 19 anos (Mann et al., 2010) embora se reconheça que possam existir subestimativas devido ao facto deste ser um fenómeno subdeclarado.

Supõe-se que a incidência dos comportamentos suicidários na adolescência esteja correlacionada com um conjunto de factores que marcam esta fase de desenvolvimento e que advêm das rápidas alterações psicológicas, biológicas e sociais que marcam a adolescência e que tornam os adolescentes mais vulneráveis (Pelkonen & Marttunen, 2003). Para Saraiva (2006), estes comportamentos são meios de apagar a angústia da dor psíquica quando não existem outras ferramentas psicológicas para lidar com o conflito, o fracasso e as perdas. Por outro lado, as crescentes taxas de prevalência de perturbações mentais na adolescência constituem igualmente factores de risco para o suicídio juvenil (Cicchetti & Toth, 1998; Lundin, Lundberg, Allebeck & Hemmingsson, 2011), bem como a prática de comportamentos de risco (Thullen, Taliaferro & Muehlenkamp, 2016).

No espectro dos comportamentos suicidários, a relevância dos comportamentos auto-lesivos tem sido alvo de crescente atenção pública e científica (e.g. Halicka & Kiejna, 2015), criando a necessidade de isolar conceptualmente um tipo particular de comportamentos que é mais comum na população adolescente e de jovens adultos (Klonsky & Olino, 2008). Assim, embora os comportamentos suicidários e os comportamentos auto-lesivos possam ser considerados fenómenos distintos, a investigação tem apontado para a presença de uma contiguidade entre ambos e para a sua associação (e.g. Gouveia-Pereira, Gomes, Santos, Frazão & Sampaio, 2016; Muehlenkamp, Claes, Havertape & Plener, 2012; Webb, 2002), tal como será abordado seguidamente.

Divergências Conceptuais e Definições

Os comportamentos auto-lesivos foram primeiramente referenciados em contexto clínico em 1880, embora não fossem diferenciados de outros problemas comportamentais associados a certas perturbações psicopatológicas (Favazza, 1998). Neste contexto, o termo "auto-mutilação" denominava os danos físicos que certos pacientes esquizofrénicos ou com estados melancólicos infligiam a si próprios. Estas auto-lesões eram usualmente dirigidas aos orgãos genitais, aos olhos e às mãos, especialmente durante a experienciação de delírios místicos. Deste modo, os comportamentos auto-lesivos eram perspectivados como uma manifestação severa de uma perturbação mental, sendo considerados um estado crónico que obrigava ao internamento e tratamento intensivo (Graff & Mallin, 1967).

Tal como relembra Roe-Sepowitz (2007), a primeira abordagem por parte da literatura psiquiátrica a comportamentos auto-lesivos surgiu em 1913, quando Emerson apresentou um caso psicanalítico em que considerava a auto-mutilação como um substituto simbólico da masturbação. Posteriormente, no ano de 1935, Menninger distinguiu pela primeira vez comportamentos suicidários de comportamentos auto-lesivos, afirmando que estes últimos seriam a expressão não-fatal de um desejo de morte atenuado (Menninger, 1935) e um acto para evitar o suicídio e promover a auto-cura (Menninger, 1938).

A partir da década de 1970, o paradigma em torno dos comportamentos auto-lesivos começou a abandonar gradualmente o seu foco exclusivo nas teorias da psicossexualidade freudiana, e os esforços para clarificar o alcance clínico destes comportamentos aumentaram (e.g. Carr, 1977; Lester, 1972). Em 1980, os comportamentos auto-lesivos foram incluídos na terceira edição do *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; *American Psychiatric Association*, 1980) como um sintoma da perturbação de personalidade limite (personalidade *borderline*).

Mais recentemente, a auto-injúria não-suicida (*non-suicidal self-injury*, NSSI) passou a integrar a quinta edição deste manual (DSM-V; *American Psychiatric Association*, 2013), constando no capítulo referente às condições para estudos posteriores e acompanhando o crescente foco científico nos comportamentos auto-lesivos. Neste sentido, a primeira década do século XXI poderá ser considerada como "a década dos comportamentos auto-lesivos", uma vez que os investigadores e técnicos de saúde mental têm sido responsáveis pela produção de uma avalanche de informação para a categorização, análise, explicação e tratamento destes comportamentos (Millard, 2013).

Actualmente, é possível encontrar na literatura termos tão distintos como auto-injúria não-suicida, auto-mutilação, *cutting*, auto-injúria deliberada, violência auto-infligida, parassuicídio, comportamentos auto-lesivos, auto-agressão, entre outros. No entanto, várias destas denominações são utilizadas para classificar um mesmo fenómeno e, por vezes, um mesmo termo é utilizado para classificar comportamentos distintos. Estas divergências conceptuais têm gerado disparidades no seio da generalização teórica e da partilha de conceptualizações, bem como dificuldades no avanço a nível investigacional.

Uma das designações mais utilizadas consiste nos "comportamentos auto-lesivos", embora existam também alguns problemas na sua definição. Tal como Mangnall e Yurkovich (2008) sumarizam, alguns autores (e.g. Conaghan & Davidson, 2002) consideram que esta designação se refere a comportamentos sem uma intenção suicida, enquanto outros autores

(e.g. Klonsky, Oltmanns & Turkheimer, 2003; Ross & Heath, 2002) afirmam que esta denominação abarca somente comportamentos com intenção suicida. Há igualmente autores (e.g. Guerreiro, Sampaio, Figueira & Madge, 2017; Hawton, Rodham, Evans & Weatherall, 2002; Hawton et al., 2012; Hurry, 2000; Madge et al., 2008; O'Connor, Rasmussen, Miles & Hawton, 2009) que consideram que os comportamentos auto-lesivos englobam ambos os tipos de comportamentos mencionados.

Deste modo, os comportamentos auto-lesivos podem ser definidos consoante o tipo de intenção subjacente, ou de acordo com as suas características ou resultados comportamentais, sem ter em conta a intencionalidade suicida. Esta divisão teórica observa-se particularmente a nível geográfico, uma vez que os investigadores Norte-Americanos costumam utilizar esta denominação para classificar danos físicos auto-infligidos sem intenção suicida, enquanto os investigadores Britânicos e Europeus a utilizam como designação para comportamentos de danos físicos auto-infligidos independentemente da intenção (Skegg, 2005).

No entanto, a questão da intencionalidade é difícil de operacionalizar. Assim, outro factor que contribui para os problemas em torno da definição da intencionalidade consiste na dificuldade em clarificar qual a intenção ou motivo subjacentes ao próprio comportamento auto-lesivo. Neste sentido, um sujeito que não se pretenda suicidar pode escolher um método auto-lesivo letal (muitas vezes por falta de conhecimentos correctos), e um sujeito que se pretenda suicidar pode optar por um método que resulte de forma não letal (Bagley & Ramsay, 1997). Esta problemática da intencionalidade também se relaciona com o próprio conceito de deliberação, no sentido em que um sujeito que pratica um comportamento auto-lesivo pode não ter a intenção (consciente ou inconsciente) de causar a lesão ou o dano propriamente ditos (Strong, 2000). De igual modo, este comportamento pode não ser realizado deliberadamente, e sim como resultado de um acto impulsivo (Fox & Hawton, 2004). Ainda por acréscimo, muitas vezes as razões apresentadas como motivos para a realização de tentativas de suicídio incluem intenções não suicidas, tal como a expressão de sofrimento e o desejo de escapar a situações problemáticas (Hawton & James, 2005). Por último, a intenção pode igualmente ser construída através da própria narrativa do acto, influenciada por elementos dos contextos psicopatológico, cultural, religioso e filosófico (Grandclerc, De Labrouhe, Spodenkiewicz, Lachal & Moro, 2016).

Neste sentido, Sampaio (1991) afirma que o gesto suicida está envolto em significado relacional, apesar de ser um acto individual. Assim, a tentativa de suicídio do adolescente pode ser categorizada em quatro tipos fundamentais: a) como um apelo, em que o adolescente

faz um pedido de ajuda; b) como um desafio, em que o adolescente tem como objectivo a mudança e o gesto suicida aparece na maioria das vezes dirigido a uma pessoa com quem está em conflito; c) como uma fuga, em que o adolescente pretende a mudança e para tal se exclui e isola a nível familiar e social; d) como um renascimento, em que o adolescente pretende com a sua morte nascer de novo, aguardando que o seu sistema relacional se organize de uma forma diferente (Sampaio, 1991).

Para além das ambiguidades em torno da classificação destes comportamentos, existe igualmente algum debate conceptual quanto à severidade necessária para que os mesmos sejam considerados como um acto auto-lesivo. Retirar a crosta de uma pequena ferida, por exemplo, poderá ser visto como algo normal ou aceitável até determinado nível, enquanto comportamentos mais severos de auto-lesão (como a auto-mutilação) serão normalmente indicativos de algum tipo de disfunção ou patologia (Jacobson & Gould, 2007). Desta forma, questiona-se se os comportamentos auto-lesivos existirão numa linha contínua que abarca comportamentos subclínicos de auto-lesão superficial e comportamentos clínicos de auto-lesão moderada e severa, ou se serão comportamentos distintos que representam fenómenos diferenciados entre si (Croyle & Waltz, 2007).

Assim, e embora o conceito de comportamentos auto-lesivos possua definições divergentes que reflectem a própria complexidade deste fenómeno (Best, 2006), optámos por utilizar esta designação, independentemente da intencionalidade subjacente aos comportamentos. A CASE (*Child and Adolescent Self-Harm in Europe*), responsável por um dos maiores estudos internacionais sobre comportamentos auto-lesivos na adolescência efectuados até à data (Madge et al., 2008) define os comportamentos auto-lesivos como comportamentos sem uma consequência fatal no qual um indivíduo inicia deliberadamente um acto com um propósito auto-agressivo. Assim, estes comportamentos incluem cortar-se, queimar-se, bater no ou com o corpo, saltar de um local elevado, ingerir fármacos em doses superiores às posologias terapêuticas recomendadas, ingerir uma droga ilícita ou substância psicoactiva, ingerir uma substância ou objeto não ingeríveis, entre outros comportamentos auto-agressivos. Esta definição vai também ao encontro da proposta pelo Plano Nacional de Prevenção do Suicídio (Carvalho et al., 2013)

Devemos sublinhar que esta definição exclui as perturbações do comportamento alimentar e o consumo de substâncias psicoactivas sem um intuito auto-agressivo, tendo em conta que o dano físico daí resultante é considerado um dano colateral. Há que destacar, também, a existência de comportamentos com um cariz auto-lesivo que são culturalmente

aceites e que não se apresentam como um problema (Turp, 2003). Estes incluem formas de modificação corporal como os *piercings* e as tatuagens, que também são excluídos desta classificação por constituírem uma forma de expressão cultural ou artística culturalmente sancionada. Contudo, os limites entre estes comportamentos não são claros, uma vez que a modificação corporal pode expressar liberdade pessoal e autenticidade, mas também dismorfia corporal e desejos auto-destrutivos (Hicinbothem, Gonsalves & Lester, 2006).

Os comportamentos auto-lesivos envolvem uma multiplicidade de possíveis métodos que podem ser utilizados com um intuito auto-agressivo. Diversos estudos realizados com amostras da comunidade concluíram que os métodos mais frequentes são os cortes e as sobredosagens (Madge et al., 2008); cortes, arranhões e bater com/no próprio corpo (Nixon, Cloutier e Jansson, 2008); cortes e danificação da pele através de outros meios (Brunner et al., 2013); ou as mordeduras, os arranhões e a interferência com a cicatrização de feridas (Calvete, Orue, Aizpuru & Brotherton, 2015). Algumas das investigações realizadas em Portugal revelam que os métodos mais comuns são os cortes, os arranhões, as mordeduras e bater com/no próprio corpo (Gonçalves, Martins, Rosendo, Machado & Silva, 2012; Gouveia-Pereira et al, 2016).

Em termos da severidade dos métodos utilizados para a realização de comportamentos auto-lesivos, é possível fazer uma categorização de acordo com a sua gravidade, evitando a exclusão de comportamentos mais “leves”. Embora esta categorização não seja consensualmente utilizada na literatura (e.g. Croyle & Waltz, 2007; Whitlock, Muehlenkamp & Eckenrode, 2008) usualmente são definidos três níveis de gravidade (leve, moderado e severo) consoante o nível de lesão provocado. Assim, as tentativas de suicídio poderão ser consideradas como a forma mais extrema de comportamentos auto-lesivos (Lundh, Karim & Quilisch, 2007).

Esta ideia vai ao encontro da perspectiva de que estes comportamentos se inserem num *continuum* suicidário, juntamente com a ideação suicida, as tentativas de suicídio e o suicídio consumado. Esta perspectiva é sustentada por diversos autores (e.g. Skegg, 2005; Stanley, Winchel, Molcho, Simeon & Stanley, 1992; Sun, 2011), embora não seja ainda claro em que ponto deste *continuum* os comportamentos auto-lesivos se poderão posicionar.

A Teoria da "Porta de Entrada" (*Gateway Theory*), por exemplo, coloca os comportamentos auto-lesivos no início desta linha contínua e o suicídio no final da mesma (e.g. Brausch & Gutierrez, 2010; Linehan, 1986). Esta teoria sugere que os comportamentos auto-lesivos funcionarão como a porta de entrada neste *continuum*, levando a formas mais

extremas de auto-lesão (como as tentativas de suicídio), da mesma forma que a marijuana é vista como a droga que funciona como uma porta de entrada para as drogas duras. Alguns dos factores que sustentam esta teoria baseiam-se na ideia de que os comportamentos auto-lesivos e os comportamentos suicidários partilham atributos e características comuns, independentemente da intenção subjacente (Stanley, Gameroff, Michalsen & Mann, 2001). Por acréscimo, vários estudos concluíram que os comportamentos auto-lesivos são um factor de risco para as tentativas de suicídio, sendo que uma história prévia de comportamentos auto-lesivos é um dos factores preditivos mais fortes das tentativas de suicídio, tanto em estudos transversais, como longitudinais (e.g., Boxer, 2010; Chartrand, Sareen, Toews, & Bolton, 2012; Hawton & Harriss, 2008; Zahl & Hawton, 2004).

Focando a relação entre os comportamentos auto-lesivos e a ideação suicida, Victor, Styer e Washburn (2015) propõem três hipóteses explicativas. A primeira hipótese afirma que é possível que a exposição a experiências de vida stressantes/difíceis funcione como uma terceira variável, contribuindo não só para a utilização dos comportamentos auto-lesivos como forma de lidar com elementos stressantes, como também para um maior desejo de fugir a esses elementos através do suicídio. De acordo com outra das hipóteses explicativas postuladas pelos autores, é possível que os comportamentos auto-lesivos ocorram em primeiro lugar (para regular estados internos) e que, quando a prática destes comportamentos falhe e não permita a atenuação do sofrimento emocional, a sua severidade aumente, assim como a suicidalidade. A última hipótese baseia-se na ideia de que os sujeitos com ideação suicida possam subsequentemente aperceber-se de que os comportamentos auto-lesivos podem ajudar a "melhorar" estes pensamentos a curto prazo, o que levará a um aumento da utilização destes comportamentos com intuitos de auto-regulação emocional, correndo o risco de se tornar um problema crónico.

Em suma, adoptamos nesta tese a ideia de que os comportamentos auto-lesivos fazem parte de um *continuum* suicidário, englobando assim comportamentos com e sem intencionalidade suicida e que podem ou não ocorrer na presença de pensamentos suicidas. Utilizamos, então, esta definição em detrimento da distinção dicotómica entre comportamentos auto-lesivos e tentativas de suicídio.

Funções e Características dos Comportamentos Auto-Lesivos

Os comportamentos auto-lesivos são um fenómeno complexo, com implicações multidimensionais e multideterminadas (Klonsky, 2007a). Diversas investigações têm vindo a

explorar diferentes facetas e componentes destes comportamentos, embora ainda não tenha sido encontrado um modelo consensual que especifique qual a sua etiologia. Contudo, existem alguns factores que caracterizam este fenómeno, seguidamente explicitados.

A distribuição demográfica e a prevalência dos comportamentos auto-lesivos apresentam algumas variações e considera-se que sejam uma subestimativa da prevalência real. Tal como resume Best (2006), as dificuldades em determinar a prevalência exacta destes comportamentos assentam em três componentes. Em primeiro lugar, a escala deste fenómeno depende da própria definição do conceito (cuja problemática foi anteriormente referida), sendo que quanto mais abrangente este fôr, maior será a sua prevalência. Em segundo lugar, a identificação e sinalização clínica das situações de comportamentos auto-lesivos serão apenas uma percentagem diminuta do total de ocorrências, uma vez que os sujeitos que apresentam estes comportamentos nem sempre procuram ajuda ou recebem tratamento hospitalar (Hurry, 2000). Por último, mesmo quando os actos auto-lesivos requerem tratamento médico, os números e a estatística das ocorrências não são monitorizados sistematicamente (Fox & Hawton, 2004). A estas dificuldades acresce a incerteza das técnicas de recolha de dados que utilizem o auto-relato, muitas das vezes condicionadas pelo efeito da desejabilidade social ou pela omissão de comportamentos.

Tal como previamente mencionado, ao longo do tempo tem-se verificado um aumento das taxas de prevalência destes comportamentos na faixa etária dos adolescentes e jovens adultos. Especificamente em Portugal, as investigações realizadas apontam para uma prevalência entre os 7.3% e os 30% (Carvalho, Motta, Sousa & Cabral, 2017; Gonçalves et al., 2012; Gouveia-Pereira et al., 2016; Guerreiro et al., 2017), o que vai ao encontro de vários estudos internacionais (Brunner et al., 2013; Laye-Gindhu & Schonert-Reichl, 2005; Muehlenkamp et al., 2012; Muehlenkamp & Gutierrez, 2004, 2007; Plener, Libal, Keller, Fegert & Muehlenkamp, 2009; Ross & Heath, 2002). Em amostras clínicas de adolescentes que se encontram a receber algum tipo de tratamento no âmbito da saúde mental, a prevalência apresenta valores mais elevados, oscilando entre os 40% e os 80% (Darche, 1990; DiClemente, Ponton & Hartley, 1991; Nock, 2010; Nock & Prinstein, 2004; Perez, Venta, Garnaa & Sharp, 2012).

A idade de início destes comportamentos situa-se geralmente entre os 12–14 anos (Dickey, Reisner & Juntunen, 2015; Kumar, Pepe & Steer, 2004; Muehlenkamp & Gutierrez, 2004; Nixon, Cloutier & Aggarwai, 2002; Nock & Prinstein, 2004; Ross & Heath, 2002; Saraff, Trujillo & Pepper, 2015). Supõe-se que o decurso destes comportamentos em termos

da sua frequência na história de vida do adolescente apresente um pico de ocorrências nos anos médios da adolescência e se vá desvanecendo até à idade adulta (Jacobson & Gould, 2007; Plener, Schumacher, Munz & Groschwitz, 2015). É provável que estas variações quanto à faixa etária dos sujeitos que apresentam comportamentos auto-lesivos reflictam os diferentes ritmos desenvolvimentais e conflitos intrapessoais e interpessoais durante a adolescência, bem como a mudança das motivações subjacentes à prática destes comportamentos em idades distintas (Hawton & Harriss, 2008).

A frequência com que os adolescentes realizam comportamentos auto-lesivos varia consideravelmente, não existindo ainda dados conclusivos neste âmbito. Calcula-se que estas variações se poderão relacionar com o grau de perturbação ou psicopatologia existentes no adolescente (Jacobson & Gould, 2007). A título exemplificativo, num estudo levado a cabo por Muehlenkamp e Gutierrez (2007) 25% dos sujeitos que afirmaram ter praticado algum comportamento auto-lesivo revelaram tê-lo feito apenas uma vez, 33% entre duas a três vezes, 20% mais do que quatro vezes, e aproximadamente 25% da amostra não referiu qual a frequência destes actos. Numa outra investigação (Ross & Heath, 2002), 13.1% da amostra referiu apresentar comportamentos diários de auto-lesão, 27.9% uma frequência bisemanal, 19.6% uma frequência bimensal, e 18% apenas um incidente deste tipo.

Deve-se sublinhar o facto de que grande parte dos sujeitos que praticaram estes comportamentos o fizeram poucas vezes, e que apenas uma minoria revela manter um historial crónico e contínuo de comportamentos auto-lesivos (Klonsky & Muehlenkamp, 2007). Desta forma, é provável que seja a combinação entre características biológicas, fisiológicas e psicológicas o que leva alguns adolescentes a utilizar e a manter estes comportamentos como um mecanismo de *coping*, enquanto outros adolescentes apenas os experimentam uma vez e não os repetem no futuro (Jacobson & Gould, 2007).

Em termos da distribuição por género dos comportamentos auto-lesivos na adolescência, o senso comum postula que os sujeitos do sexo feminino apresentam mais frequentemente este tipo de actos. No entanto, embora a maioria dos estudos realizados com amostras de adolescentes da comunidade corrobore esta ideia (Laye-Gindhu & Schonert-Reichl, 2005; Ross & Heath, 2002; Muehlenkamp & Gutierrez, 2007; Zlotnick, Mattia & Zimmerman, 1999), há igualmente estudos em que não foram encontradas diferenças significativas entre ambos os géneros (Muehlenkamp & Gutierrez, 2004; Stanley et al., 2001; Zoroglu et al., 2003).

O conhecimento das funções dos comportamentos auto-lesivos é um dos factores mais importantes neste âmbito, uma vez que pode contribuir para a compreensão da etiologia deste fenómeno, bem como para a sua classificação, prevenção e tratamento (Klonsky, 2007b; Klonsky, 2011). Sabe-se que estes comportamentos servem diversas funções psicológicas, que podem ocorrer em simultâneo (Lloyd-Richardson, 2008). Apresentamos seguidamente as sete funções mais estudadas pela literatura (Klonsky, 2007b): Auto-Regulação do Afecto, Anti-Dissociação, Anti-Suicídio, Fronteiras Interpessoais, Influência Interpessoal, Auto-Punição e Procura de Sensações.

Algumas investigações sugerem que os comportamentos auto-lesivos podem assentar numa estratégia disfuncional de regulação do afecto (Claes, Klonsky, Muehlenkamp, Kuppens & Vandereycken, 2010; Kimball & Diddams, 2007). Esta é a explicação mais comummente referida para estes comportamentos, baseando-se na ideia de que estes indivíduos experienciam uma excitação extrema e intolerável em resposta a acontecimentos stressantes, e que a prática de comportamentos auto-lesivos levará à cessação desta excitação, seja devido à distracção, à libertação de endorfinas, ou a um outro mecanismo ainda desconhecido (Nock & Mendes, 2008). Assim, esta função de auto-regulação do afecto serve como uma estratégia pessoal para aliviar emoções intensas e opressivas (Bjärehed & Lundh, 2008; Klonsky & Muehlenkamp, 2007).

Outra das funções mencionadas pela literatura consiste na anti-dissociação. De acordo com este modelo funcional, os comportamentos auto-lesivos são uma resposta a períodos de dissociação ou despersonalização (Klonsky, 2007b), com o intuito de terminar estes episódios. Deste modo, alguns dos sujeitos que apresentam estes comportamentos afirmam que muitas vezes se sentem irreais ou incapazes de sentir, e que os actos auto-lesivos são utilizados como uma forma de interromper estes episódios dissociativos e de os trazer de volta à realidade (Klonsky & Muehlenkamp, 2007; Malikov, 2006). Consoante este autores, é possível que as funções da anti-dissociação e da regulação do afecto se sobreponham, uma vez que os episódios de dissociação ou despersonalização podem ser um resultado das intensas emoções que estes sujeitos sentem.

Ainda de acordo com Klonsky e Muehlenkamp (2007), uma vez que os comportamentos auto-lesivos estão ligados à função da regulação do afecto e têm a potencialidade de aliviar emoções negativas, podem também funcionar como um tipo de anti-suicídio, isto é, como uma forma de resistência perante fortes ideações ou desejos suicidas. De acordo com esta função, os comportamentos auto-lesivos são perspectivados como uma forma

de expressar pensamentos suicidas sem arriscar a morte, servindo como um evitamento ou substituição do desejo de cometer suicídio (Suyemoto, 1998).

Existem também indivíduos que utilizam os comportamentos auto-lesivos como uma forma de afirmar os limites do *self* (Klonsky, 2007b; Suyemoto, 1998). Esta função, denominada de fronteiras interpessoais, assenta na ideia de que a marcação da pele (que separa os sujeitos do meio e das outras pessoas) é uma afirmação da distinção entre o eu e o outro, criando a ilusão de que alcançam sentimentos de independência e autonomia (Klonsky & Muehlenkamp, 2007). Esta perspectiva promove também a ideia de uma suprema omnipotência e torna a auto-lesão algo atraente para a componente mais vulnerável do *self* que necessita de protecção (Farber, 2008).

Há autores que referem a existência de um outro tipo de função, consistindo na influência interpessoal. Este modelo estipula que os comportamentos auto-lesivos podem ser utilizados para influenciar ou manipular pessoas (Chowanec, Josephson, Coleman & Davis, 1991; Muehlenkamp, Brausch, Quigley & Whitlock, 2013). Neste âmbito, estes comportamentos são conceptualizados como um pedido de ajuda, uma forma de evitar o abandono, ou uma tentativa para modificar o comportamento de outrém (Allen, 1995), ou ainda como uma tentativa de despoletar determinadas respostas por parte das figuras de autoridade ou do grupo de pares, particularmente em contextos clínicos, escolares ou correccionais (Klonsky & Muehlenkamp, 2007).

Outra das funções apresentadas na literatura consiste na auto-punição, sugerindo que os comportamentos auto-lesivos são uma expressão de raiva em relação ao eu (Klonsky, 2007b). Esta função vai ao encontro dos resultados investigacionais que sublinham o papel da auto-derrogação e da baixa auto-estima nestes indivíduos (Klonsky et al, 2003). Por acréscimo, esta função remete também para a experienciação dos actos auto-lesivos como comportamentos ego-sintónicos, que se tornam uma forma de controlar emoções fortes e negativas (Klonsky, 2007b).

Certos sujeitos apresentam como motivação central para a prática de comportamentos auto-lesivos o desejo de experimentar novas sensações, nomeadamente como um meio para experienciar excitação e satisfação (Klonsky & Muehlenkamp, 2007). Esta função intitula-se procura de sensações e baseia-se na ideia de que estes comportamentos podem ser vividos como uma forma de gerar excitação, assemelhando-se aos desportos radicais (Nixon et al., 2002). De acordo com Klonsky (2007b), esta função tem recebido menos atenção por parte da literatura, provavelmente por ser incomum em populações clínicas.

Embora as funções anteriormente apresentadas sejam as mais referidas pela literatura (Klonsky, 2007b), existem também outras funções. Há autores, tais como Conterio e Lader (1998) e Favazza (1987) que perspectivam os comportamentos auto-lesivos como a libertação, expressão, ou comunicação de emoções que um sujeito será incapaz de expressar de outro modo, nomeadamente através da simbolização do sofrimento (Klonsky & Glenn, 2009). Outros autores destacam igualmente a existência de funções como a vingança (Klonsky, 2007b; Rabi, Sulochana & Pawan, 2017; Rodham, Hawton & Evans, 2004), o auto-cuidado (Klonsky & Glenn, 2009), a autonomia (Klonsky & Glenn, 2009), a ligação com os pares (Klonsky & Glenn, 2009), ou a resistência (Klonsky & Glenn, 2009).

No sentido de categorizar as várias funções psicológicas dos comportamentos auto-lesivos, Nock e Prinstein (2004, 2005) propuseram o Modelo dos Quatro Factores. Neste modelo, as funções são organizadas de acordo com dois eixos: automático/social e positivo/negativo. Consoante estes autores, existem funções automáticas (que correspondem a uma dimensão intrapessoal) e funções sociais (que correspondem a uma dimensão interpessoal) que podem ser reforçadas de forma positiva ou negativa, originando quatro tipos distintos de funções. Assim, as funções automáticas negativas reduzem estados afectivos, as funcoes automáticas positivas criam estados afectivos, as funções sociais negativas permitem fugir a determinadas interacções sociais, e as funções sociais positivas têm como objectivo despoletar alguma atenção ou reacção dos outros (Kortge, Meade & Tennant, 2013; Nock, 2010; Nock & Prinstein, 2004, 2005).

Os modelos ligados às funções automáticas/intrapessoais têm sido mais explorados pela literatura (e.g. Andover & Morris, 2014; Chapman, Gratz, & Brown, 2006), principalmente por serem também os mais frequentemente relatados pelos sujeitos com comportamentos auto-lesivos (Klonsky, 2009). No entanto, nos últimos anos as funções sociais/interpessoais têm vindo a ganhar maior destaque (Muehlenkamp et al., 2013).

Um dos grandes focos investigacionais na área dos comportamentos auto-lesivos tem consistido na identificação de múltiplos factores associados aos mesmos, nomeadamente factores predisponentes, factores de risco, ou factores de manutenção (Fliege, Lee, Grimm & Klapp, 2009). Em termos de categorização, a literatura distingue factores ambientais ou interpessoais, que se referem a elementos condicionantes externos ao indivíduo, e factores de risco individuais ou intrapessoais, que se baseiam em características internas e psicológicas.

Em termos gerais, os factores interpessoais relacionados com a prática de comportamentos auto-lesivos englobam a existência de uma história familiar de

comportamentos suicidários (Brent & Mann, 2005; Deliberto & Nock, 2008; Hawton, Haw, Houston & Townsend, 2002; Jobes & Schneidman, 2006), história de abuso sexual (Cavanaugh, 2002; Gratz, Conrad & Roemer, 2002; Madge et al., 2011; Noll, Horowitz, Bonanno, Trickett & Putnam, 2003; Zoroglu et al., 2003), traumas infantis (Gratz et al., 2002; Marchetto, 2006; Zoroglu et al., 2003), negligência infantil (Crittendon, 1992; Kogan & Carter, 1996), eventos de vida negativos ou stressantes (Madge et al., 2011), isolamento social (Mahadevan, Hawton & Casey, 2010), entre outros.

Os factores de cariz intrapessoal incluem a emocionalidade negativa (Suyemoto, 1998), défices na gestão de emoções (Klonsky & Muehlenkamp, 2007), alexitimia (Zlotnick, Shea, Pearlstein, Simpson, Costello & Begin, 1996; Lambert & Man, 2007), impulsividade (Glenn & Klonsky, 2010; Lockwood, Daley, Townsend & Sayal, 2017; Madge et al., 2011) baixa auto-estima (Hawton et al., 2002; Laye-Gindhu & Schonert-Reichl, 2005; Lundh et al., 2007), comportamentos anti-sociais (Ayton, Rasool & Cottrell, 2003; Jacobson & Gould, 2007), entre outros.

Existem igualmente alguns dados sobre os diagnósticos comórbidos dos comportamentos auto-lesivos. Para além da relação destes comportamentos com a perturbação de personalidade *borderline* (Baker, Crawford, Brown, Lipsedge & Carter, 2008; Ferrara, Terrinoni & Williams, 2012; Vega et al., 2017), o diagnóstico mais comum no seio dos adolescentes que apresentam estes comportamentos consiste na depressão major, com taxas de prevalência entre os 41.6% e os 58% (Kumar et al., 2005; Nock, Joiner, Gordon, Lloyd-Richardson & Prinstein, 2006; Jacobson, Muehlenkamp, Miller & Turner, 2008), e em outros quadros de sintomatologia depressiva (Boone & Brausch, 2016; Brunner et al., 2013; Carneiro, Azenha & Peixoto, 2017; Santos, Saraiva & De Sousa, 2009; Serras, Saules, Cranford & Eisenberg, 2010; Taliaferro & Muehlenkamp, 2015).

Por acréscimo, sintomas simultâneos de perturbações depressivas e perturbações da ansiedade também estão fortemente associados aos comportamentos auto-lesivos (Andover, Pepper, Ryabchenko, Orrico & Gibb, 2005; Klonsky et al., 2003; Ross & Heath, 2002; Tuisku et al., 2006). Existem igualmente estudos que apontam para a coexistência entre comportamentos auto-lesivos e perturbações dissociativas (Matsumoto, Yamaguchi, Takeshi, Okada, Yoshikawa & Hirayasu, 2005; Saxe, Chawla & Van der Kolk, 2002), stress pós-traumático (Viana, Dixon, Berenz & Espil, 2017) distúrbios alimentares como a bulimia e a anorexia (Jeppson, Richards, Hardman & Granley, 2003; Mahadevan et al., 2010; Ross, Heath & Toste, 2009; Taliaferro & Muehlenkamp, 2015) e ansiedade (Brunner et al., 2013;

Chartrand et al., 2012). No entanto, embora estes diagnósticos sejam frequentes nesta população, a presença destes comportamentos não implica necessariamente a existência de um diagnóstico particular (Klonsky & Muehlenkamp, 2007).

Apesar de existirem evidências no âmbito da identificação de factores e comorbilidades associados aos comportamentos auto-lesivos, estes comportamentos não devem ser considerados como a consequência de uma resposta a um único elemento pessoal, e sim como o resultado de múltiplos factores, muitas vezes acumulados ao longo da vida (Fortune, Seymour & Lambie, 2005). Assim, é necessária investigação mais profunda no sentido de criar modelos que incorporem em simultâneo factores interpessoais e intrapessoais, tal como a sua interacção, a fim de melhor reflectir a complexa etiologia deste fenómeno.

Focando as investigações realizadas em Portugal, até à data são ainda escassos os estudos que se tenham centrado nas funções dos comportamentos auto-lesivos, bem como as características e factores associados aos mesmos (Carneiro et al., 2017; Carvalho et al., 2017; Gonçalves et al., 2012; Guerreiro et al., 2009; Guerreiro et al., 2017; Guerreiro, Sampaio, Rihmer, Gonda & Figueira, 2013; Jorge, Queirós & Saraiva, 2015; Saraiva, Peixoto & Sampaio, 2014). Segundo a revisão realizada por Guerreiro & Sampaio (2013), que inclui também estudos realizados no Brasil, a literatura científica em língua Portuguesa tem ainda uma contribuição modesta. Os autores destacam o relevo global dado ao estudo dos comportamentos auto-lesivos, especificamente em jovens, uma vez que têm existido evoluções a nível conceptual, bem como estudos epidemiológicos e clínicos relevantes e com potencial de modular estratégias de prevencão e tratamento.

A Importância da Esfera Interpessoal

Embora os comportamentos auto-lesivos sejam usualmente considerados pelo adolescente como algo da sua esfera privada/pessoal e muitas vezes este não os reconheça como um problema (Fortune, Sinclair & Hawton, 2008), a esfera interpessoal desempenha um papel importante neste âmbito. De facto, o suporte social pode ser de extrema relevância para a intervenção e prevenção destes comportamentos, particularmente por parte da família e dos pais, do grupo de pares, e do *staff* escolar. Uma investigação realizada por Muehlenkamp e colegas (2013), por exemplo, concluiu que os adolescentes com comportamentos auto-lesivos afirmavam ter menos pessoas de confiança em seu redor e percepcionavam menor suporte social quando comparados com adolescentes sem estes comportamentos.

Para além das funções interpessoais inerentes a estes comportamentos, um dos momentos em que esta importância se revela será a procura de ajuda por parte do adolescente. Um estudo realizado por Nixon e colegas (2008) revelou que 56% dos adolescentes com comportamentos autolesivos da sua amostra procuraram ajuda para a sua situação, sendo que 56% recorreram a amigos, 54% recorreram a um psicólogo/psiquiatra, 48% recorreram à sua família, 32% recorreram a outros profissionais de saúde mental, 30% ao médico de família, 28% a outras fontes de ajuda não especificadas, e 18% recorreram a linhas telefónicas de ajuda. Estes dados são corroborados por outros estudos que sublinham a importância do suporte social no processo de procura de ajuda (De Leo & Heller, 2004; Hasking, Rees, Martin & Quigley, 2015; Rowe, French, Henderson, Ougrin, Slade & Moran, 2014).

A família parece ocupar um papel central no âmbito da intervenção clínica, sendo que as terapias e tratamentos com uma orientação interpessoal e que incorporem a ligação familiar e o treino de capacidades comunicacionais parecem ser especialmente bem sucedidas na redução dos comportamentos auto-lesivos (Muehlenkamp et al., 2013; Sutton, 2007). Os pais assumem particular importância neste contexto (e.g. Miner, Love & Paik, 2016; Santos, 2007), uma vez que um ambiente familiar afectuoso e preocupado com o adolescente, onde exista espaço para a discussão aberta destes comportamentos, pode favorecer o processo de recuperação do adolescente (Arbuthnott & Lewis, 2015).

Os professores e o *staff* escolar demonstram igualmente constituir um importante factor na sinalização destes comportamentos, bem como na sua prevenção e intervenção (e.g. Berger, Hasking, Reupert, 2014; Best, 2006). Porém, tal como Evans e Hurrell (2016) sistematizaram na sua revisão de literatura, existem diversas dificuldades no enquadramento escolar.

Primeiramente, os comportamentos auto-lesivos são muitas vezes considerados invisíveis em contextos educativos, uma vez que não são incluídos nos conteúdos curriculares, embora os estudantes expressem essa necessidade. Por acréscimo, quando os actos auto-lesivos transgridem as normas institucionais, estas ocorrências são muitas vezes vistas como “mau comportamento”, o que implica a inexistência de um acompanhamento adequado às especificidades destes comportamentos. Em terceiro lugar, as directivas escolares que obrigam à referenciação de situações de comportamentos auto-lesivos a peritos externos (como psicólogos ou psiquiatras) acabam por contribuir para a ausência da procura de ajuda por parte dos alunos que desejem suporte confidencial dos professores. Um quarto aspecto a referir consiste no facto da ansiedade e do *stress* associados à performance escolar poderem

escalar a prática de comportamentos auto-lesivos e mesmo o suicídio. Por último, o *bullying* em contexto escolar pode contribuir para estes comportamentos, embora esta associação não seja reconhecida pelas escolas.

Deve-se também salientar o papel do grupo de pares, que pode simultaneamente ser um elemento de risco, ou um elemento protector (e.g. Evans, Hawton & Rodham, 2005; Heath, Ross, Toste, Charlebois & Nedecheva, 2009). Diversos estudos têm destacado o efeito da modelação e contágio social dos comportamentos auto-lesivos (Jarvi, Jackson, Swenson & Crawford, 2013), à semelhança de outros comportamentos do especto suicidário (Haw, Hawton, Niedzwiedz & Platt, 2013; Niedzwiedz, Haw, Hawton & Platt, 2014). Adicionalmente, existem outros estudos cujos resultados demonstram a falta de empatia e de informação por parte do grupo de pares quando é confrontado com comportamentos auto-lesivos (Hasking et al., 2015), podendo contribuir para o agravamento dos mesmos.

Capítulo II. Representações Sociais sobre os Comportamentos Auto-Lesivos

A par do aumento da prevalência dos comportamentos auto-lesivos e do subsequente foco investigacional nesta área, a visibilidade destes comportamentos nos media tem também aumentado. Desta forma, os indivíduos podem ser confrontados mais frequentemente com a existência destes comportamentos fora do seu enquadramento científico ou clínico. Concomitantemente, as elevadas taxas de prevalência dos comportamentos auto-lesivos em adolescentes da comunidade podem levar a um maior conhecimento destes comportamentos, como por exemplo por parte de pais, professores, amigos, ou colegas de escola. Por consequência, a tomada de conhecimento da existência deste fenómeno pode originar a construção de determinadas representações sobre o mesmo, bem como a modificação de representações já existentes.

As representações sociais podem ser definidas como uma modalidade do conhecimento que produz e determina comportamentos, uma vez que define a natureza dos estímulos que nos rodeiam e o significado das respostas que lhes damos (Moscovici, 1961). Por outro lado, as representações sociais são um conjunto de valores, ideias ou práticas, elaborados e partilhados socialmente, que regulam a relação do indivíduo com o mundo e que constituem um instrumento de orientação, de percepção das situações e de elaboração de respostas (Moscovici, 1973). Tendo em conta que são também responsáveis pela estruturação da realidade, possibilitam a integração e classificação de novos factos, facilitando a comunicação entre os diversos indivíduos, e sendo igualmente construídas através dessa comunicação (Moscovici, 1963).

Importa sublinhar o carácter dinâmico destas representações, pois são recriadas e transformadas no decorrer das comunicações e das interacções no interior de um determinado grupo social (Moscovici, 1961), dependendo também da pertença e identificação social dos indivíduos aos seus grupos sociais (Gouveia-Pereira, Amaral, & Soares, 1997). Assim, visam a produção de comportamentos e interacções sociais e não somente a reprodução de determinados comportamentos como reacções a estímulos exteriores (Sampaio, Oliveira, Vinagre, Gouveia-Pereira, Santos & Ordaz, 2000).

Por conseguinte, as representações sociais são simultaneamente um produto e um processo (e.g. Jodelet, 1984; Moscovici, 1961; Valsiner, 2003), cuja dinâmica permite aos sujeitos interpretar e conceber aspectos da realidade para agir em relação a eles (Wachelke & Camargo, 2007). Enquanto produto, é possível estudar-se o seu conteúdo que circula como

versão do real, impregnando os discursos, as imagens, as opiniões e as atitudes que os diversos canais de informação veiculam; como processo, remetem para os mecanismos psicológicos e sociais que estão na base da formação/organização/transformação de tais conteúdos e também para as suas funções e eficácia sociais (Sampaio et al., 2000).

No contexto concreto dos comportamentos auto-lesivos, a construção e possível modificação destas representações assume particular relevância devido a alguns factores. Primeiramente, e tal como já mencionámos, estes comportamentos podem orientar-se por diversas funções interpessoais, para além das funções intrapessoais (Muehlenkamp et al., 2013). Em segundo lugar, a relação com o outro assume um papel muito importante em vários aspectos dos comportamentos auto-lesivos, nomeadamente na revelação dos mesmos a outrém e na procura de ajuda por parte do adolescente (Hasking et al., 2015; Klineberg, Kelly, Stansfeld & Bhui, 2013; Muehlenkamp et al., 2013; Rowe et al., 2014), na prestação de apoio durante o acompanhamento e tratamento do adolescente (Baetens et al., 2015), e na criação de estratégias de prevenção destes comportamentos (Berger, Hasking & Martin, 2013). Por último, e no contexto desta tese, estas representações são importantes porque os nossos participantes pertencem a grupos sociais diferentes: com e sem comportamentos auto-lesivos, e adolescentes e respectivos pais.

No geral, a literatura tem reconhecido a importância de explorar e descrever as representações sobre os comportamentos auto-lesivos e as atitudes quanto aos mesmos. Não obstante, a grande maioria dos estudos existentes dedicou-se à descrição das atitudes e experiências de diferentes tipos de populações relativamente a vários aspectos dos comportamentos auto-lesivos.

No que se refere a adolescentes, estes estudos centrados nas atitudes/experiências incluem jovens com práticas auto-lesivas (Batejan, Swenson, Jarvi & Muehlenkamp, 2015; Klineberg et al., 2013; Milnes, Owens & Blenkiron, 2002; Rissanen, Kylmä & Laukkanen, 2008) e o grupo de pares destes adolescentes (Berger et al., 2013; Bresin et al., 2013). Em termos de investigações com adultos, estas têm-se também centrado no estudo de atitudes/experiências, incluindo pais de adolescentes com comportamentos auto-lesivos (Ferrey et al., 2016; Kelada, Whitlock, Hasking & Melvin, 2016; McDonald, O'Brien & Jackson, 2007; Oldershaw, Richards, Simic & Schmidt, 2008; Rissanen, Kylmä & Laukkanen, 2009), profissionais e técnicos de saúde (Bosman & van Meijel, 2008; Karman, Kool, Poslawsky & Van Meijel, 2015; McHale & Felton, 2010; Conlon & O'Tuathail, 2012; Rees, Rapport, Thomas, John & Snooks, 2014; Whitlock, Eells, Cummings, & Purington, 2009),

técnicos de saúde mental (De Stefano, Atkins, Noble & Heath, 2012; Fox, 2011; Jeffery & Warm, 2002; Long & Jenkins, 2010), estudantes de saúde mental (Fox, 2016), professores (Berger et al., 2014; Heath, Toste & Beettam, 2007; Heath, Toste, Sornberger & Wagner, 2011), entre outros.

Mais recentemente começaram a surgir estudos que focam factores como as perspectivas sobre a prevenção dos comportamentos auto-lesivos (Berger, Hasking & Martin, 2017), ou a influência da etnicidade e cultura na compreensão destes comportamentos (Kokaliari, Roy, Panagiotopoulos & Al-Makhamreh, 2017).

Porém, continua a existir um desconhecimento geral quanto às representações sociais sobre os comportamentos auto-lesivos e sobre as funções dos mesmos, devido a quatro factores centrais: 1) o corpo investigacional tem-se dedicado principalmente ao estudo de atitudes e experiências relativas a este fenómeno; 2) são escassos os dados sobre indivíduos que não tenham tido contacto interpessoal ou profissional directo com comportamentos auto-lesivos; 3) existem poucos estudos que comparem os resultados de populações distintas e que analisem as suas divergências; 4) uma grande parte das investigações efectuadas utilizam metodologias qualitativas, que permitem o aprofundamento teórico desta área, mas que limitam a generalização e replicação de resultados. Especificamente em Portugal, tanto quanto sabemos não foram efectuados estudos que explorassem as representações sobre as funções dos comportamentos auto-lesivos.

Destacamos, contudo, um estudo relevante no âmbito das representações das funções dos comportamentos auto-lesivos, desenvolvido por Batejan e colegas (2015). Estes autores compararam as perspectivas sobre as funções dos comportamentos auto-lesivos de estudantes com e sem uma história destes comportamentos. Para tal, utilizaram o *Inventory of Statements About Self-Injury* (Klonsky & Glenn, 2009), um instrumento que inclui uma primeira secção com uma listagem de comportamentos auto-lesivos e uma segunda secção que caracteriza 13 funções destes comportamentos (agrupadas nas dimensões interpessoal e intrapessoal). Os dados recolhidos foram analisados de acordo com as dimensões interpessoal e intrapessoal das funções. Os resultados obtidos mostraram que, no global, ambos os grupos de participantes partilharam as mesmas perspectivas sobre as funções dos comportamentos auto-lesivos. No entanto, os participantes sem comportamentos auto-lesivos enfatizaram mais algumas funções interpessoais do que participantes sem uma história destes comportamentos.

Num outro estudo, Bresin e colegas (2013) analisaram as perspectivas de estudantes com e sem comportamentos auto-lesivos sobre estes mesmos comportamentos, utilizando

vinhetas ficcionais (para cada vinheta os participantes tinham de seleccionar uma de quatro funções previamente estipuladas). Embora os autores não tenham considerado a possível história de comportamentos auto-lesivos dos participantes, os resultados revelaram que os estudantes apresentavam consideráveis dificuldades em compreender os motivos que podem levar um adolescente a praticar estes comportamentos.

Sublinhamos, então, a importância e necessidade da exploração das representações sobre as funções dos comportamentos auto-lesivos na adolescência. Esta compreensão poderá contribuir para evitar o estigma, as atitudes negativas e as respostas desadequadas perante este fenómeno (Bresin et al., 2013) e, simultaneamente, ajudar no desenvolvimento de programas de prevenção e intervenção que englobem a esfera interpessoal do adolescente.

Representações Sociais dos Comportamentos Auto-Lesivos nos Media

Focando o papel dos media, há que relembrar que as representações sociais veiculadas pelos meios de comunicação social são uma forma de construção de sentido e produção de realidades públicas, objectivas e legitimadas, embora os significados produzidos pelos media constituam apenas um dos ingredientes de que se alimenta o pensamento individual, grupal e colectivo (Ordaz & Vala, 1997; Rodríguez-Zoya e Rodríguez-Zoya, 2015).

Em termos gerais, a literatura existente focada na relação do suicídio e dos meios de comunicação social pode ser incluída numa de duas categorias: a) a abordagem que os media fazem do tema em termos da natureza do suicídio ou da tentativa de suicídio (como algo bizarro ou sensacionalista, por exemplo); b) análises de como a divulgação mediática de suicídios poderá ter um impacto e influenciar outros comportamentos suicidários (Cullen, 2006; Gould, Jamieson & Romer, 2003; Krysinska et al., 2017; Machlin, Pirkis & Spittal, 2013; Mok, Jorm & Pirkis, 2015; Mueller, 2017; Stack, 2000). Em Portugal, as investigações sobre representações de comportamentos suicidários nos meios de comunicação social têm-se centrado maioritariamente no suicídio, mais especificamente nas representações da imprensa generalista (Araújo, Pinto-Coelho & Lopes, 2016; Ordaz & Vala, 1997).

Tal como foi previamente mencionado, a visibilidade dos comportamentos auto-lesivos nos meios de comunicação social tem aumentado (Whitlock, Purington & Gershkovich, 2009), especialmente na *internet* (Marchant et al., 2017; Richardson, Surmitis & Hyldahl, 2012; Swannell, Martin, Krysinska, Kay, Olsson & Win, 2010; Whitlock et al., 2007; Whitlock, Powers & Eckenrode, 2006), em particular nos *social media* (Canady, 2017; Dyson

et al., 2016; Murray & Fox, 2006; Niwa & Mandrusiak, 2012; Reddy, Rokito & Whitlock, 2016; Zdanow & Wright, 2012) e noutros contextos, como o cinema (Radovic & Hasking, 2013; Trewavas, Hasking & McAllister, 2010). Este aumento reflecte-se também em termos de outros comportamentos suicidários, igualmente com maior enfâse nos novos media surgidos na *internet* (Biddle et al., 2016; Haim, Arendt & Scherr, 2017; Kwan, 2017).

É importante destacar esta crescente presença de referências a comportamentos auto-lesivos na *internet*, especialmente porque este tem demonstrado ser um meio em que os adolescentes comunicam entre si com a finalidade de receber suporte e validação para as suas experiências auto-lesivas (Adams, Rodham, & Gavin, 2007; Johnson, Zastawny, & Kulpa, 2010; Lewis & Baker, 2011; Lewis, Heath, Sornberger, & Arbuthnott, 2012; Lewis, Heath, St Denis, & Noble, 2011). Por outro lado, estas representações *online* de comportamentos auto-lesivos podem ter um efeito negativo através da normalização e reforço destes comportamentos (Lewis & Baker, 2011; Lewis et al., 2011; Lewis et al., 2012; Whitlock et al., 2006), da sua apresentação de uma forma que minimiza as suas consequências (Lewis & Baker, 2011), e de modo a que alguns elementos mais gráficos possam despoletar novos episódios auto-lesivos em adolescentes que já pratiquem estes comportamentos (Lewis & Baker, 2011; Lewis et al., 2011).

Assim, esta visibilidade nos media acarreta diversas influências e consequências. Por um lado, a normalização dos comportamentos auto-lesivos pode ser benéfica para os adolescentes que apresentem estes comportamentos, no sentido em que se poderão sentir menos isolados e possivelmente mais apoiados, podendo mesmo ser incentivados a procurar ajuda (D'Onofrio, 2007; Whitlock, Lader & Conterio, 2007). Por outro lado, esta influência pode ser negativa, sendo que alguns adolescentes poderão mesmo vir a adoptar esta prática como uma forma de lidar com o *stress* e outras emoções negativas (Hodgson, 2004; Reddy et al., 2016; Zhu et al., 2016).

Apesar de existir cada vez mais investigações sobre este fenómeno, são escassos os estudos centrados nas representações dos media sobre os comportamentos auto-lesivos (Whitlock et al., 2009), e que explorem a forma como estas podem modificar ou influenciar as representações dos próprios indivíduos.

Overview dos Estudos Empíricos

Apesar da extensa literatura sobre os comportamentos auto-lesivos, do reconhecimento da importância da esfera interpessoal no âmbito dos mesmos, e da crescente visibilidade

destes comportamentos nos media, são escassos os estudos que se tenham debuçado sobre as representações sociais construídas sobre este fenómeno, nomeadamente em termos das representações sociais sobre as funções dos comportamentos auto-lesivos. Assim, o objectivo central desta tese consiste na exploração e caracterização das representações sociais sobre as funções destes comportamentos em: 1) adolescentes sem e com uma história de comportamentos auto-lesivos; 2) adultos, i.e., pais (mãe e pai) de adolescentes com e sem uma história de comportamentos auto-lesivos; 3) famílias (filho/a, mãe e pai) de adolescentes com e sem uma história de comportamentos auto-lesivos.

Para cumprir estes objectivos e tendo em conta a escassez de instrumentos validados para adolescentes Portugueses, bem como a inexistência de instrumentos direccionados para a exploração das representações sociais sobre as funções dos comportamentos auto-lesivos, o conjunto de estudos empíricos que compõem esta tese é globalmente orientado por dois grandes eixos investigacionais. O primeiro consiste na adaptação, construção e validação de instrumentos, nomeadamente do Inventário de Comportamentos Auto-Lesivos (ICAL), do Questionário de Representações sobre as Funções dos Comportamentos Auto-Lesivos para Adolescentes (QRFCAL-Adolescentes) e do Questionário de Representações sobre as Funções dos Comportamentos Auto-Lesivos para Adultos (QRFCAL-Adultos). O segundo eixo incide no estudo das representações sociais previamente mencionadas.

Assim, no artigo 1, denominado "Adaptação e Validação do Inventário de Comportamentos Auto-Lesivos para Adolescentes (Secção I do *Inventory of Statements About Self-Injury*)", apresentamos os resultados da adaptação e validação da secção I do *Inventory of Statements About Self-Injury* (Klonsky & Glenn, 2009) para adolescentes Portugueses. Esta adaptação foca-se exclusivamente na primeira secção deste instrumento, correspondendo à listagem de comportamentos, e compreende dois estudos que analisam as qualidades psicométricas deste inventário.

O artigo 2 intitula-se "Social Representations about the Functions of Deliberate Self-Harm from Adults and Adolescents: A Qualitative Study". Este artigo apresenta uma análise qualitativa de várias entrevistas, com adolescentes com e sem comportamentos auto-lesivos e adultos sem uma história destes comportamentos, focando-se na descrição e comparação das representações sociais sobre as funções dos comportamentos auto-lesivos destes três grupos. Este estudo teve dois objectivos: 1) compreender quais os conteúdos representacionais sobre as funções dos comportamentos auto-lesivos referidos por estes três grupos e 2) utilizar os conteúdos representacionais não referidos na literatura para a construção dos dois

questionários destinados à caracterização das representações sociais sobre as funções dos comportamentos auto-lesivos, seguidamente mencionados.

Os dois artigos que se seguem (artigo 3 e 4) apresentam a construção e validação de dois questionários para o estudo das representações sociais sobre as funções dos comportamentos auto-lesivos para adolescentes (artigo 3) e para adultos (artigo 4). Estes instrumentos foram desenvolvidos com base na segunda secção do *Inventory of Statements About Self-Injury* (Klonsky & Glenn, 2009), na análise anteriormente mencionada de entrevistas e na análise de uma amostra da imprensa escrita generalista Portuguesa. O artigo 3 – "Representations about the Functions of Deliberate Self-Harm: Construction and Validation of a Questionnaire for Portuguese Adolescents" consiste na validação deste instrumento para adolescentes e inclui dois estudos de cariz psicométrico. De igual modo, o artigo 4, intitulado "Representations about the Functions of Deliberate Self-Harm: Construction and Validation of a Questionnaire for Portuguese Adults", foca-se na validação deste instrumento para adultos, incluindo igualmente dois estudos de cariz psicométrico.

Por último, o quinto e o sexto artigos focam-se no estudo das representações sociais sobre as funções dos comportamentos auto-lesivos, tendo sido utilizados os instrumentos previamente validados: Inventário de Comportamentos Auto-Lesivos (ICAL); Questionário das Representações sobre as Funções dos Comportamentos Auto-Lesivos para Adolescentes (QRFCAL-Adolescentes); e Questionário das Representações sobre as Funções dos Comportamentos Auto-Lesivos para Adultos (QRFCAL-Adultos).

O artigo 5, denominado "Social Representations About the Functions of Deliberate Self-Harm: Adolescents and Parents", teve dois objectivos. O primeiro consistiu na comparação das representações sociais sobre as funções dos comportamentos auto-lesivos de adolescentes com e sem uma história destes comportamentos. O segundo objectivo centrou-se na comparação das representações sociais sobre as funções dos comportamentos auto-lesivos de mães e pais de adolescentes com e sem comportamentos auto-lesivos. O artigo 6, intitulado "How do Families Represent the Functions of Deliberate Self-Harm?: A Comparison Between the Social Representations from Adolescents and Their Parents", seguiu a mesma linha investigacional, focando-se em famílias. Assim, este artigo baseou-se na descrição e comparação das representações sociais sobre as funções dos comportamentos auto-lesivos em famílias (filho/a, mãe e pai) de adolescentes com e sem estes comportamentos.

Secção II

Secção Empírica

Adaptação e Validação do Inventário de Comportamentos Auto-Lesivos para Adolescentes (Secção I do *Inventory of Statements About Self-Injury*)*

Eva Duarte[1], Maria Gouveia-Pereira[1] & Daniel Sampaio[2]

Resumo

Os comportamentos auto-lesivos são actualmente considerados um problema de saúde pública, afectando principalmente adolescentes e jovens adultos. Estes comportamentos podem ser realizados através da utilização de diversos métodos.

O presente estudo baseia-se na adaptação e validação da primeira secção do *Inventory of Statements About Self-Injury*, desenvolvido por Klonsky e Glenn (2009), que avalia a presença de vários tipos de comportamentos auto-lesivos e respectiva frequência. Foram acrescentados novos itens e uma escala de resposta categorizada de acordo com a frequência dos comportamentos.

O primeiro estudo consistiu numa análise factorial exploratória com uma amostra de 131 adolescentes. Os resultados revelaram uma estrutura de três factores designados como *Comportamentos Auto-Lesivos Severos e Tentativas de Suicídio*, *Comportamentos Auto-Lesivos Leves/Moderados* e *Consumo de Substâncias Psicoactivas*. A escala total e os três factores apurados apresentaram boa consistência interna. Esta estrutura foi posteriormente corroborada no segundo estudo, através de uma análise factorial confirmatória que revelou um modelo de ajustamento aceitável.

Esta versão do Inventário de Comportamentos Auto-Lesivos apresenta uma estrutura relativamente sólida e assente em características psicométricas aceitáveis, possibilitando a sua utilização em futuras investigações.

Palavras-Chave: Comportamentos Auto-Lesivos; Inventário; Validação; Adolescentes

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* Artigo submetido na revista *Análise Psicológica*

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Introdução

Os comportamentos auto-lesivos nos adolescentes são actualmente um problema de saúde pública. Estima-se que em Portugal estes comportamentos tenham uma prevalência na população adolescente entre os 7.3% e os 28% (Gonçalves, Martins, Rosendo, Machado & Silva, 2012; Guerreiro, Sampaio, Figueira & Madge, 2017), à semelhança dos resultados de outros estudos internacionais (Brunner et al., 2013; Muehlenkamp, Claes, Havertape & Plener, 2012).

O objectivo do presente estudo consiste na adaptação e validação, para os adolescentes Portugueses, da primeira secção do *Inventory of Statements About Self-Injury* (Klonsky e Glenn, 2009), que avalia a prática de diversos tipos de comportamentos auto-lesivos.

Existem divergências quanto à definição conceptual destes comportamentos, nomeadamente em relação à presença ou ausência de intencionalidade suicida. Esta falta de consenso impede muitas vezes a generalização de resultados. Utilizamos no presente estudo as definições propostas no Plano Nacional de Prevenção do Suicídio (2013) que define os comportamentos auto-lesivos como comportamentos com ou sem intencionalidade suicida, envolvendo actos auto-lesivos intencionais que incluem cortar-se, saltar de um local elevado, ingerir fármacos em doses superiores às posologias terapêuticas recomendadas, ingerir uma droga ilícita ou substância psicoactiva, ou ingerir uma substância ou objeto não ingeríveis, sempre com um propósito declaradamente auto-agressivo. Esta definição vai ao encontro da enunciada no CASE Study (Madge et al, 2008), cuja investigação incidiu sobre os comportamentos auto-lesivos e envolveu sete países.

Importa salientar que os comportamentos auto-lesivos são um fenómeno complexo, com implicações multidimensionais e multideterminadas (Klonsky, 2007a). As investigações nesta área têm vindo a explorar diferentes facetas e componentes destes comportamentos, embora ainda não tenha sido encontrado um modelo multifactorial consensual que especifique qual a sua etiologia.

Sabe-se que estes comportamentos têm diversas funções psicológicas. Assim, algumas investigações sugerem que os comportamentos auto-lesivos podem assentar numa estratégia disfuncional de regulação do afecto (Claes, Klonsky, Muehlenkamp, Kuppens & Vandereycken, 2010; Kimball & Diddams, 2007). Existem igualmente investigações que apontam para outras possíveis funções, como a auto-punição ou o direccionamento de raiva contra o próprio, o desejo de experienciar novas sensações, a tentativa de influência sobre

outrém, ou como forma de interromper episódios dissociativos (Klonsky, 2007b; Klonsky & Muehlenkamp, 2007). Existem ainda autores, tais como Conterio, Lader e Bloom (1998) e Favazza (1996) que perspectivam os comportamentos auto-lesivos como a libertação, expressão, ou comunicação de emoções que um indivíduo será incapaz de expressar de outro modo.

Por outro lado, os comportamentos auto-lesivos envolvem uma multiplicidade de possíveis métodos que podem ser utilizados com um intuito auto-agressivo, desde cortes e arranhões, até ao consumo de álcool e substâncias psicoactivas. No entanto, existem discrepâncias nos estudos realizados quanto à prevalência dos vários métodos auto-lesivos, principalmente quando são comparadas amostras clínicas e amostras da comunidade. As investigações realizadas com amostras clínicas têm demonstrado que os métodos auto-lesivos mais comuns incluem cortes, sobredosagens, queimaduras e estrangulação (Jacobson, Muehlenkamp, Miller & Turner, 2008), cortes, arranhões e asfixia (Zhand, Matheson e Courtney, 2016), e bater com/no próprio corpo, cortes, arranhões e queimaduras (Swannell, Martin, Scott, Gibbons & Gifford, 2008).

No que se refere a amostras da comunidade, alguns estudos concluíram que os métodos mais frequentes são os cortes e as sobredosagens (Madge et al., 2008); cortes, arranhões e bater com/no próprio corpo (Heath, Joly & Carsley, 2016; Nixon, Cloutier e Jansson, 2008); cortes e danificação da pele através de outros meios (Brunner et al., 2013); ou as mordeduras, os arranhões e a interferência com a cicatrização de feridas (Calvete, Orue, Aizpuru & Brotherton, 2015). Algumas investigações realizadas em Portugal revelam que os métodos mais comuns são os cortes, os arranhões, as mordeduras e bater com/no próprio corpo (Gonçalves et al., 2012; Gouveia-Pereira, Gomes, Santos, Frazão & Sampaio, 2016). Em suma, e embora existam discrepâncias entre os dados existentes, o corte do tecido corporal é um dos métodos mais comuns, tanto em amostras clínicas como em amostras da comunidade.

Os comportamentos auto-lesivos podem também ser categorizados de acordo com a gravidade ou a severidade dos métodos. Embora esta categorização não seja consensualmente utilizada na literatura (e.g. Croyle & Waltz, 2007; Whitlock, Muehlenkamp & Eckenrode, 2008) usualmente são definidos três níveis de gravidade (leve, moderado e severo) consoante o nível de lesão provocado no tecido corporal. Assim, e mantendo a perspectiva de que estes comportamentos se inserem num *continuum* suicidário (Skegg, 2005; Stanley, Winchel, Molcho, Simeon & Stanley, 1992; Sun, 2011), as tentativas de suicídio poderão ser

consideradas como a forma mais extrema ou severa de comportamentos auto-lesivos.

O conhecimento da diversidade e quantidade de métodos utilizados para a realização de comportamentos auto-lesivos é um factor relevante, uma vez que poderá estar associado a um maior desajuste psicológico global do indivíduo (Jacobson & Gould, 2007). De igual modo, diferentes estudos concluíram que o recurso a um elevado número de métodos utilizados é um preditor de tentativas de suicídio (Nock, Joiner, Gordon, Lloyd-Richardson & Prinstein, 2006; Stewart et al., 2017) e está positivamente correlacionado com a presença de ideação suicida (Gouveia-Pereira et al., 2016; Victor, Styer & Washburn, 2015).

A construção de instrumentos para avaliar estes comportamentos teve início na década de 90 e o seu desenvolvimento tem acompanhado a própria evolução das conceptualizações e definições dos comportamentos auto-lesivos (Craigen, Healey, Walley, Byrd & Schuster, 2010). Existem diversos instrumentos que incluem alguns itens que remetem para comportamentos auto-lesivos. Destacamos, por exemplo, o *Risk-Taking and Self-Harm Inventory for Adolescents* (Vrouva, Fonagy, Fearon, & Roussow, 2010) que engloba comportamentos auto-lesivos e comportamentos de risco; e a *Self-Injurious Thoughts and Behaviors Interview* (Nock, Holmberg, Photos & Michel, 2007), que para além da caracterização de comportamentos auto-lesivos, avalia também a existência de ideação suicida e planos/actos suicidas. Por outro lado, existem instrumentos que se focam exclusivamente nos comportamentos auto-lesivos, como o *Non-Suicidal Self-Injury Assessment Tool* (Whitlock, Exner-Cortens & Purington, 2014), o *Deliberate Self-Harm Inventory* (Gratz, 2001), ou o *Self-Injury Questionnaire* (Alexander, 1999; Santa Mina, Gallop & Links, 2006).

O instrumento que aqui nos propomos adaptar e validar consiste na primeira secção do *Inventory of Statements About Self-Injury,* que denominaremos de Inventário de Comportamentos Auto-Lesivos (ICAL). Este instrumento foi desenvolvido por Klonsky e Glenn (2009), destinando-se originalmente a adolescentes e jovens adultos. Os autores construíram este instrumento a partir da revisão da literatura existente, da discussão com investigadores com conhecimentos sobre o tema e da análise do conteúdo de *websites* criados por e para adolescentes que apresentem estes comportamentos. Compõe-se por duas secções: a primeira avalia a estimativa da realização de doze comportamentos auto-lesivos ao longo da vida, a segunda caracteriza compreensivamente treze funções destes comportamentos.

Optámos pela adaptação deste instrumento uma vez que apresenta de forma clara e sucinta vários tipos de comportamentos auto-lesivos, possibilitando a sua utilização nos âmbitos clínico e investigacional. De igual forma, este inventário tem sido utilizado em

diversas investigações que abordam o fenómeno dos comportamentos auto-lesivos, nomeadamente em amostras de adolescentes da comunidade (Somer, Bildik, Kabukçu-Başay, Güngör, Başay & Farmer, 2015), adolescentes em internamento psiquiátrico (Victor, Glenn & Klonsky, 2012), estudantes universitários (Hamza & Willoughby, 2013, 2014; Heath et al., 2016; Klonsky & Olino, 2008; Saraff, Trujillo, Pepper, 2015), ou transgéneros (Dickey, Reisner & Juntunen, 2015). Por acréscimo, foi também adaptado e validado para a população Sueca (Lindholm, Bjärehed & Lundh, 2011) e Turca (Bildik, Somer, Kabukçu-Başay, Başay & Özbaran, 2013).

As qualidades psicométricas do *Inventory of Statements about Self-Injury* têm sido continuamente exploradas. Focando especificamente a primeira secção deste instrumento, têm sido apresentado valores do coeficiente do *alpha* de Cronbach entre os .79 (Bildik et al., 2013) e os .84 (Klonsky & Olino, 2008), revelando boa consistência interna. Em termos da confiabilidade teste-reteste, alguns estudos realizados (Bildik et al., 2013; Glenn & Klonsky, 2011) demonstram que esta secção apresenta correlações teste-reteste entre os .52 e os .83 (com médias de .66 a .68).

Como já referimos, o presente estudo teve como principal objectivo a adaptação e validação da primeira secção do *Inventory of Statements about Self-Injury*, proposto por Klonsky e Glenn (2009) para o grupo etário dos adolescentes, tendo em conta que existe uma escassez de instrumentos exclusivamente destinados à avaliação e caracterização dos comportamentos auto-lesivos em Portugal. Embora os comportamentos auto-lesivos possam ser realizados simultaneamente através de vários métodos (e.g. Klonsky & Olino), consideramos pertinente a sua categorização de acordo com os níveis de severidade dos comportamentos, uma vez que comportamentos mais severos/graves estão mais associados a psicopatologias e também a um maior risco de suicídio (Whitlock et al., 2008). Por acréscimo, de acordo com Whitlock e colegas (2008), as tipologias dos comportamentos auto-lesivos poderão implicar diferentes abordagens psicoterapêuticas e de tratamento. Assim, uma vez que não foram encontradas investigações que analisassem a estrutura factorial da primeira secção deste instrumento, efectuámos dois estudos. O primeiro estudo consiste numa análise factorial exploratória e o segundo baseia-se numa análise factorial confirmatória, contando ambos com a análise da consistência interna. Adicionalmente, tendo em conta a escassez de investigações em Portugal que apresentem dados detalhados sobre os métodos utilizados no âmbito dos comportamentos auto-lesivos, optámos igualmente por efectuar uma análise da sua prevalência na amostra em estudo.

Estudo 1: Análise Factorial Exploratória

Método

Participantes.

Os participantes utilizados para o primeiro estudo consistem em 131 adolescentes com comportamentos auto-lesivos, estudantes de escolas do ensino básico e secundário do distrito de Lisboa. Estes 131 participantes fazem parte de uma amostra inicial de 620 adolescentes, correspondendo a 21.1% da mesma.

Deste modo, 42 (32.1%) participantes são do sexo masculino e 89 (67.9%) do sexo feminino. As suas idades estão compreendidas entre os 12 e os 19 anos, com uma média de 16.1 anos (DP=1.8). A tabela 1 apresenta mais detalhadamente os dados sócio-demográficos dos participantes.

Tabela 1. Estudo 1 – Dados sócio-demográficos dos participantes (N=131)

		n	%
Nacionalidade	Portuguesa	125	95.4
	Brasileira	3	2.3
	Romena	3	2.3
Nível de Escolaridade	7º	9	6.9
	8º	12	9.2
	9º	21	16
	10º	49	37.4
	11º	32	24.4
	12º	8	6.1
Reprovações	Sem Reprovações	67	51.1
	Uma Reprovação	41	31.3
	Mais do que uma Reprovação	23	17.5
Irmãos	Sem Irmãos	21	16
	1 Irmão	54	41.2
	2 Irmãos	32	24.4
	3 ou Mais Irmãos	24	18.4
Estado Civil dos Pais	Casados	71	54.2
	Divorciados	35	26.7
	Solteiros	15	11.5
	União de Facto	8	6.1
	Viúvo/a	2	1.5

Instrumentos.

Para a recolha de dados foi construído um inquérito que inclui um breve questionário sócio-demográfico e a versão adaptada e traduzida do instrumento em estudo. O questionário sócio-demográfico baseava-se em questões relativas ao género, idade, nacionalidade, número de reprovações, número de irmãos e estado civil dos pais dos participantes.

O processo de tradução da primeira secção do *Inventory of Statements About Self-Injury* esteve a cargo de três peritos na área com conhecimentos da língua Inglesa, sendo cada uma dessas traduções posteriormente retrovertida para Inglês por outros três peritos com conhecimento desta língua. As versões finais foram comparadas com o instrumento original e seleccionaram-se os itens considerados mais semelhantes. Foi igualmente realizada a validação facial do instrumento com um grupo de 12 adolescentes, no sentido de analisarmos se a linguagem dos itens era compreendida por todos de igual modo.

A versão resultante do procedimento anterior foi aplicada a 396 estudantes pertencentes ao terceiro ciclo e ensino secundário, com idades compreendidas entre os 14 e 19 anos. Após a análise dos resultados e a consulta de investigadores com experiência no estudo de comportamentos auto-lesivos, foram adicionados e reformulados alguns dos comportamentos enumerados no inventário. Assim, a listagem de comportamentos passou a ser composta por 14 itens: *cortei-me* (item original), *mordi-me* (item original), *queimei-me* (item original), *cravei/gravei símbolos ou palavras na minha pele* (item reformulado), *puxei/arranquei o cabelo* (item original), *cocei/arranhei-me até fazer uma ferida* (item reformulado), *consumi drogas com a intenção de me magoar* (item adicionado), *espetei-me com agulhas* (item original), *engoli substâncias perigosas com a intenção de me magoar* (item reformulado), *bebi em excesso com a intenção de me magoar* (item adicionado), *bati com o corpo ou bati em mim próprio* (item original), *ingeri em demasia um medicamento com a intenção de me magoar* (item adicionado), *ingeri em demasia um medicamento com a intenção de morrer* (item adicionado), *tentei suicidar-me* (item adicionado).

Para além destas alterações, foi criada uma alternativa à modalidade de resposta original da escala, que pedia ao participante que estimasse, numa questão aberta, o número de vezes que tinha praticado cada tipo de comportamento. Assim, introduzimos quatro opções de resposta consoante a prática e a frequência destes comportamentos: "Não"; "Sim, 1 vez"; "Sim, 2 a 10 vezes"; e "Sim, mais de 10 vezes". Esta categorização permite a clarificação e uniformização de resultados, bem como a resposta mais rápida por parte do participante.

Procedimentos.

Após receber autorização por parte da Direção-Geral da Educação (DGE), através do sistema de Monitorização de Inquéritos em Meio Escolar (MIME), para a realização deste estudo, diversas instituições escolares foram contactadas a fim de confirmar a sua colaboração no mesmo. Antes da aplicação do questionário cada turma foi abordada de forma a solicitar o consentimento informado e a autorização por parte dos encarregados de educação dos alunos.

A recolha de dados efectuou-se num só momento, utilizando para tal um tempo lectivo acordado com as instituições escolares. A participação de cada aluno foi voluntária, solicitando-se o seu consentimento prévio. Foram igualmente seguidos procedimentos com o objectivo de garantir a confidencialidade dos dados e o anonimato dos participantes.

Procedimentos de Análise.

Todas as análises estatísticas foram realizadas através do software SPSS v22 (IBM SPSS, Chicago, IL).

Num primeiro momento, efectuámos uma análise factorial exploratória dos diversos comportamentos auto-lesivos. Para tal, efectuou-se previamente o teste de Kaiser-Meyer-Olkin e o teste de esfericidade de Bartlett a fim de aferir a adequabilidade da amostra para o seguimento da análise factorial. Esta análise factorial exploratória seguiu o modelo de extracção de factores pelo método das Componentes Principais e rotação ortogonal Varimax. A primeira extracção factorial permitiu a redução dos itens do instrumento. Uma segunda extracção levantou problemas ao nível das cargas factoriais dos itens e da consistência interna dos quatro factores apurados. Assim, optámos por forçar a extracção de três factores de acordo com a categorização proposta pela literatura, em que os comportamentos são agrupados de acordo com a sua severidade (leve, moderada e severa). Por último, estimámos a consistência interna de cada factor apurado através do *alpha* de Cronbach.

Resultados

Prevalência dos Comportamentos Auto-Lesivos.

Os comportamentos auto-lesivos mais referidos foram *cortei-me* (56.4%), *mordi-me* (54.2%) e *bati com o corpo ou bati em mim próprio* (38.9%). Os comportamentos menos referidos foram *ingeri em demasia um medicamento com a intenção de me magoar* (7.6%),

ingeri em demasia um medicamento com a intenção de morrer (7.6%) e *consumi drogas com a intenção de me magoar* (8.5%). A tabela 2 apresenta detalhadamente os tipos de comportamentos auto-lesivos presentes no instrumento, assim como a frequência dos mesmos.

Tabela 2. Estudo 1 – Tipos de comportamentos auto-lesivos e respectivas frequências (N=131)

	Não %	1 vez %	2-10 vezes %	mais de 10 vezes %
1. Cortei-me	43.6	19.8	29	7.6
2. Mordi-me	45.8	22.1	21.4	10.7
3. Queimei-me	78.6	12.2	4.6	4.6
4. Cravei/Gravei símbolos ou palavras na minha pele	74.7	9.2	11.5	4.6
5. Puxei/Arranquei o cabelo	67.2	14.5	13.7	4.6
6. Cocei/Arranhei-me até fazer uma ferida	71	12.2	9.2	7.6
7. Consumi drogas com a intenção de me magoar	91.5	3.1	2.3	3.1
8. Espetei-me com agulhas	87	8.4	3.8	0.8
9. Engoli substâncias perigosas com a intenção de me magoar	90.8	6.1	2.3	0.8
10. Bebi em excesso com a intenção de me magoar	79.4	10.7	7.6	2.3
11. Bati com o corpo ou bati em mim próprio	61.1	13.7	20.6	4.6
12. Ingeri em demasia um medicamento com a intenção de me magoar	92.4	5.3	2.3	-
13. Ingeri em demasia um medicamento com a intenção de morrer	92.4	6.1	1.5	-
14. Tentei suicidar-me	87.7	9.2	3.1	-

Análise Factorial Exploratória.

A fim de aferir a adequabilidade da amostra para o seguimento da análise factorial, efectuou-se previamente o teste de Kaiser-Meyer-Olkin (KMO=.725) e o teste de esfericidade de Bartlett (p=.000), que indicaram que os dados são apropriados para a realização desta análise.

Na primeira análise de extracção de factores os dados foram reduzidos a quatro factores que explicavam 60% da variância. A tabela das comunalidades revelou valores aceitáveis, embora o item 4 tenha apresentado um valor de .12. Focando este item, verificou-se que apresentava uma carga factorial máxima de .121. A análise da correlação item-total corrigida revelou que o item 4 apresentava o valor mais baixo, correspondendo a -.114. A análise da matriz de correlações inter-item permitiu constatar igualmente que este item se correlacionava negativamente com 11 itens e que os dois itens com os quais se correlacionava positivamente apresentavam valores correlacionais baixos (.06 e .68). De uma perspectiva teórica, e tendo em conta que este item remete para a gravação de palavras ou símbolos na pele (*Cravei/Gravei símbolos ou palavras na minha pele*), colocou-se a hipótese do conteúdo do item poder ter sido considerado enquanto comportamento que não causa lesão no tecido corporal (como por exemplo a escrita de palavras), ou que remete para práticas de modificação corporal como a escarificação (fugindo ao espectro dos comportamentos auto-lesivos). Com base nestes dados, decidimos retirar o item 4 do inventário.

Realizou-se, então, uma segunda análise de extracção de factores também com rotação Varimax, sem o item 4. Daqui resultou uma estrutura de quatro factores, explicando 60% da variância. No entanto, esta organização factorial levantava problemas ao nível da consistência interna dos factores apurados e das respectivas cargas factoriais. Assim, optou-se pela extracção de três factores, com base na categorização proposta na literatura. Nesta extracção, os três factores apurados explicavam 55.2% da variância, apresentavam um *eigenvalue* superior a 1 (com valores entre 1.27 e 3.57) e estavam de acordo com o *scree plot* e a percentagem de variância retida. Foram retidos os itens com carga factorial superior a .40, com valores oscilando entre .414 e .849 (ver tabela 4).

O factor I explica 27.48% da variância e corresponde aos seguintes itens: item 1 (*Cortei-me*), item 3 (*Queimei-me*), item 9 (*Engoli substâncias perigosas com a intenção de me magoar*), item 12 (*Ingeri em demasia um medicamento com a intenção de me magoar*) item 13 (*Ingeri em demasia um medicamento com a intenção de morrer*) e item 14 (*Tentei suicidar-me*). Para além da inclusão de ambos os itens que remetem para tentativas de suicídio, considerou-se que os restantes itens remetem para métodos auto-lesivos severos, de acordo com a categorização da gravidade de comportamentos auto-lesivos consoante o grau da lesão do tecido corporal (Croyle & Waltz, 2007; Skegg, 2005; Whitlock et al., 2008). Assim, esta dimensão foi apelidada de *Comportamentos Auto-Lesivos Severos e Tentativas de Suicídio* (CALSTS).

O segundo factor apurado engloba o item 2 (*Mordi-me*), item 5 (*Puxei/Arranquei o cabelo*), item 6 (*Cocei/Arranhei-me até fazer uma ferida*), item 8 (*Espetei-me com agulhas*) e item 11 (*Bati com o corpo ou bati em mim próprio*). Esta segunda componente explica 17.97% da variância. Tal como na dimensão anterior, através da análise destes itens de acordo com a gravidade dos métodos constatou-se que estes são considerados como formas leves e moderadas de auto-lesão. Assim, atribuiu-se a designação de *Comportamentos Auto-Lesivos Leves/Moderados* (CALLM) a esta dimensão.

Por último, o terceiro factor explica 9.76% da variância e é composto pelo item 7 (*Consumi drogas com a intenção de me magoar*) e item 10 (*Bebi em excesso com a intenção de me magoar*). Ambos os itens remetem para o consumo de substâncias psicoactivas enquanto método auto-lesivo, pelo que esta dimensão foi designada como *Consumo de Substâncias Psicoactivas* (CSP).

Tabela 3. Organização dos factores do Inventário de Comportamentos Auto-Lesivos após análise factorial e análise da consistência interna

Itens	CALSTS (Factor I)	CALLM (Factor II)	CSP (Factor III)
13. Ingeri em demasia um medicamento com a intenção de morrer	**.849**	-.031	.184
12. Ingeri em demasia um medicamento com a intenção de me magoar	**.784**	.001	.305
14. Tentei suicidar-me	**.663**	-.275	.019
3. Queimei-me	**.537**	.329	.131
1. Cortei-me	**.535**	.126	-.040
9. Engoli substâncias perigosas com a intenção de me magoar	**.495**	.364	.148
2. Mordi-me	-.039	**.788**	-.305
6. Cocei/Arranhei-me até fazer uma ferida	.161	**.750**	.074
5. Puxei/Arranquei o cabelo	.048	**.701**	-.151
11. Bati com o corpo ou bati em mim próprio	-.063	**.602**	.384
8. Espetei-me com agulhas	.008	**.414**	.317
7. Consumi drogas com a intenção de me magoar	.109	.027	**.834**
10. Bebi em excesso com a intenção de me magoar	.320	.030	**.821**
Eigenvalue	3.57	2.34	1.15
% Variância explicada	27.48	17.97	9.76
Alpha de Cronbach	.66	.72	.74

Análise da Consistência Interna.

A análise da consistência interna do inventário revelou que os factores apurados apresentaram valores aceitáveis do *alpha* de Cronbach (Tabela 4): factor I (CALSTS), α = .66; factor II (CALLM), α = .72; factor III (CSP), α = .74.

Estudo 2: Análise Factorial Confirmatória

Método

Participantes.

Os participantes deste estudo consistem em 109 adolescentes com comportamentos auto-lesivos, estudantes de escolas do ensino básico e secundário do distrito de Leiria. Estes 109 participantes integram uma amostra inicial de 411 adolescentes, correspondendo a 26.5% da mesma. Assim, 35 (32.1%) participantes são do sexo masculino e 74 (67.9%) do sexo feminino. As suas idades estão compreendidas entre os 12 e os 19 anos, com uma média de 15.4 anos (DP=1.8). Os restantes dados sócio-demográficos são igualmente semelhantes à amostra utilizada na análise factorial exploratória (Tabela 4).

Tabela 4. Estudo 2 – Dados sócio-demográficos dos participantes (N=109)

		n	%
Nacionalidade	Portuguesa	108	99.1
	Ucraniana	1	0.9
Nível de Escolaridade	7º	20	18.3
	8º	13	11.9
	9º	12	11
	10º	18	16.5
	11º	26	23.9
	12º	20	18.3
Reprovações	Sem Reprovações	90	82.6
	Uma Reprovação	13	11.9
	Mais do que uma Reprovação	6	5.5
Irmãos	Sem Irmãos	19	17.4
	1 Irmão	53	48.6
	2 Irmãos	25	22.9
	3 ou Mais Irmãos	12	11
Estado Civil dos Pais	Casados	63	57.8
	Divorciados	32	29.4
	Solteiros	9	8.3
	União de Facto	2	1.8
	Viúvo/a	3	2.8

Instrumentos.

Para a recolha de dados utilizou-se um inquérito que inclui um breve questionário sócio-demográfico e a versão reduzida do ICAL, de acordo com os resultados da análise factorial exploratória. O questionário sócio-demográfico baseava-se em questões relativas ao género, idade, nacionalidade, número de reprovações, número de irmãos e estado civil dos pais dos participantes.

Procedimentos.

Após receber autorização por parte da Direção-Geral da Educação (DGE), através do sistema de Monitorização de Inquéritos em Meio Escolar (MIME), contactámos várias instituições escolares a fim confirmar a sua colaboração no estudo. Cada turma foi previamente abordada de forma a solicitar o consentimento informado e a autorização por parte dos encarregados de educação dos alunos.

A recolha de dados efectuou-se num único momento, utilizando para tal um tempo lectivo acordado com as instituições escolares. A participação de cada aluno foi voluntária, solicitando-se o seu consentimento. Foram igualmente seguidos procedimentos com o objectivo de garantir o anonimato dos participantes e a confidencialidade dos dados.

Procedimentos de Análise.

Todas as análises estatísticas foram realizadas através dos *softwares* SPSS v22 e Amos Versão 22.0 (IBM SPSS, Chicago, IL).

Uma vez que as variáveis em estudo são ordinais e que apresentam uma distribuição não normal, confirmada pela observação dos valores dos coeficientes de assimetria e curtose, optou-se por utilizar o método de estimação *unweighted least squares* (Kogar & Kogar, 2015; Yang-Wallentin, Jöreskog & Luo, 2010).

O ajustamento global do modelo foi estimado através dos pesos factoriais e de vários indicadores de ajustamento. Tendo em conta que o método de estimação *unweighted least squares* fornece o mínimo da função de ajuste, mas não distribui esse valor como um qui-quadrado (Schermelleh-Engel, Moosbrugger & Müller, 2003), os indicadores utilizados incluiram o *Goodness of Fit Index* (GFI), *Adjusted Goodness of Fit Index* (AGFI), *Parsimony Goodness-of-Fit Index* (PGFI), *Normal Fit Index* (NFI), e *Root Mean Square Residual*

(RMR). São considerados aceitáveis valores de GFI e AGFI superiores a .90, valores de PGFI superiores a .60, valores de NFI superiores a .90, e valores de RMR inferiores a .10 (Arbuckle, 2013; Bentler & Bonett, 1980; Hooper, Coughlan & Mullen, 2008; Marôco, 2010).

A análise da consistência interna para cada factor apurado foi estimada através do *alpha* de Cronbach.

Resultados

Prevalência dos Comportamentos Auto-Lesivos.

Os resultados obtidos nesta segunda recolha de dados vão globalmente ao encontro dos dados do primeiro estudo, embora com algumas diferenças (Tabela 5). Assim, os métodos mais referidos foram *bati com o corpo ou bati em mim próprio* (57.8%), *mordi-me* (54.1%) e *cortei-me* (45.9%). Por outro lado, os menos referidos foram *ingeri em demasia um medicamento com a intenção de morrer* (5.5%), engoli substâncias perigosas com a intenção de me magoar (5.5%) e *tentei suicidar-me* (7.3%).

Tabela 5. Estudo 2 – Tipos de comportamentos auto-lesivos e respectivas frequências (N=109)

	Não %	1 vez %	2-10 vezes %	mais de 10 vezes %
1. Cortei-me	54.1	11	26.6	8.3
2. Mordi-me	45.9	11.9	27.5	14.7
3. Queimei-me	75.2	15.6	9.2	-
4. Puxei/Arranquei o cabelo	59.6	18.3	15.6	6.4
5. Cocei/Arranhei-me até fazer uma ferida	63.3	18.3	12.8	5.5
6. Consumi drogas com a intenção de me magoar	87.2	7.3	4.6	0.9
7. Espetei-me com agulhas	85.3	9.2	4.6	0.9
8. Engoli substâncias perigosas com a intenção de me magoar	94.5	1.8	3.7	-
9. Bebi em excesso com a intenção de me magoar	86.2	2.6	8.3	2.8
10. Bati com o corpo ou bati em mim próprio	42.2	10.1	39.4	8.3
11. Ingeri em demasia um medicamento com a intenção de me magoar	89	3.7	7.3	-
12. Ingeri em demasia um medicamento com a intenção de morrer	94.5	5.5	-	-
13. Tentei suicidar-me	92.7	6.4	0.9	-

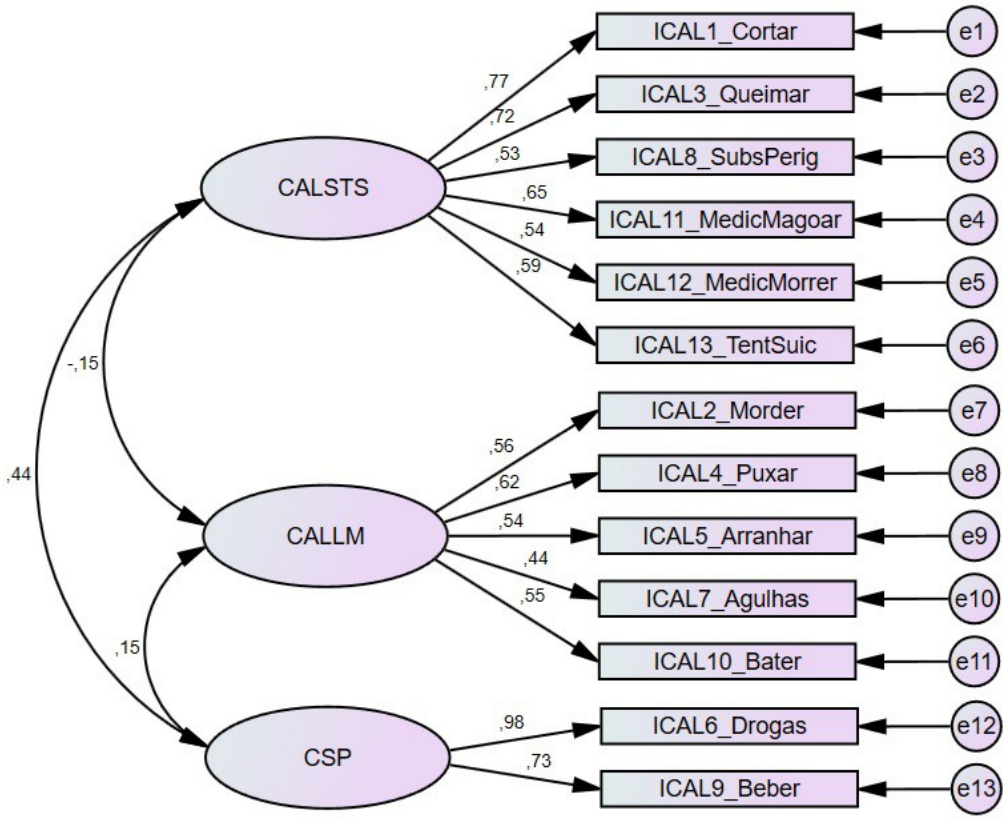
Análise Factorial Confirmatória.

O teste de Kaiser-Meyer-Olkin (KMO) revelou um valor aceitável da adequabilidade da amostral (KMO=.646) e o teste de esfericidade de Bartlett indicou que os dados eram passíveis de serem sujeitos à análise factorial (*p*=.000).

Aplicámos o procedimento de análise factorial confirmatória ao modelo resultante da análise factorial exploratória prévia. Em primeira instância, verificou-se que, com excepção do item 7 (λ=.44), todos os restantes itens apresentaram pesos factoriais elevados (>.50), tal como se verifica na Figura 1. A análise dos índices de qualidade do ajustamento revelou que GFI=.954, AGFI=.932, PGFI=.650, NFI=.857, e RMR=.050. Embora o valor de NFI tenha sido inferior ao recomendado para um bom ajustamento (>.90), há autores que consideram que valores acima dos .80 são considerados aceitáveis, uma vez que este índice é sensível ao tamanho da amostra (Bentler, 1990; Mâroco, 2010). Assim, consideramos existir um ajustamento adequado do modelo.

Focando os valores das correlações entre as três variáveis latentes, constatou-se que o Factor III se correlaciona positivamente com o Factor II e Factor I. Contudo, os factores I e II apresentam um valor correlacional negativo. Uma vez que esta correlação negativa apresenta um valor baixo, poderá remeter para a independência dos factores I e II.

Figura 1. Representação da solução estandardizada do modelo



Análise da Consistência Interna.

Os três fatores apresentaram valores do *alpha* de Cronbach indicativos de boa consistência interna: factor I (CALSTS) com um valor de α = .76, factor II (CCALLM) com um valor de α = .67 e factor III (CSP) com um valor de α = .82.

Discussão

O objectivo deste estudo consistiu na adaptação e validação da primeira secção do *Inventory of Statements About Self-Injury* para os adolescentes Portugueses, uma vez que o instrumento original (Klonsky & Glenn, 2009) tem demonstrado boas qualidades psicométricas (Glenn & Klonsky, 2011; Klonsky, et al., 2015; Kortge et al., 2013; Latimer et al., 2013) e tem sido continuamente utilizado em diversos contextos e com amostras variadas (Dickey et al., 2015; Hamza & Willoughby, 2013, 2014; Heath et al., 2016; Klonsky & Olino, 2008; Saraff et al., 2016; Somer et al., 2015; Victor et al., 2012).

Para além da tradução do instrumento original, após a consulta de especialistas no estudo de comportamentos auto-lesivos e de uma primeira aplicação do instrumento, diversos itens foram reformulados para melhor compreensão por parte dos adolescentes Portugueses, e outros itens foram adicionados ao inventário. Após este momento, foram realizados dois estudos que analisaram a validade de constructo deste instrumento. O primeiro consistiu na análise factorial exploratória do ICAL e na subsequente redução de itens. O segundo estudo baseou-se na análise factorial confirmatória do ICAL, a fim de avaliar a estabilidade da estrutura factorial do mesmo. Sublinhamos que ambos os estudos utilizaram amostras de adolescentes da comunidade com comportamentos auto-lesivos.

Assim, o processo de validação do ICAL permitiu primeiramente contribuir para o conhecimento da prevalência dos comportamentos auto-lesivos nos adolescentes Portugueses e para a caracterização dos diversos métodos utilizados. Em ambas as recolhas de dados, que envolveram adolescentes com idades entre os 12 e os 19 anos, verificámos que cerca de 21.1% (131 participantes do Estudo 1) e 26.5% (109 participantes do Estudo 2) dos participantes das amostras iniciais afirmaram ter realizado pelo menos um comportamento auto-lesivo. Estes dados vão ao encontro dos previamente encontrados na literatura nacional (Gonçalves et al., 2012; Guerreiro et al., 2017) e internacional (Brunner et al., 2013; Muehlenkamp et al., 2012).

Focando somente os participantes com comportamentos auto-lesivos, verificámos que os comportamentos mais comuns consistiram nos cortes (56.4% no Estudo 1 e 45.9% no Estudo 2), mordeduras (54.2% no Estudo 1 e 54.1% no Estudo 2) e pancadas auto-infligidas (38.9% no Estudo 1 e 57.8% no Estudo 2). Estes dados estão de acordo com os resultados de diversas investigações que utilizaram amostras semelhantes (Brunner et al., 2014; Calvete et al., 2015; Gonçalves et al., 2012; Gouveia-Pereira et al., 2016; Madge et al., 2008; Nixon et al., 2008).

Uma das novidades desta investigação foi o facto de termos realizado uma análise factorial exploratória a este inventário de comportamentos. Os resultados obtidos no primeiro estudo apresentaram uma estrutura tridimensional: *Comportamentos Auto-Lesivos Severos e Tentativas de Suicídio* (Factor I), *Comportamentos Auto-Lesivos Leves/Moderados* (Factor II) e *Consumo de Substâncias Psicoactivas* (Factor III). No segundo estudo, os resultados demonstraram que a análise factorial confirmatória corroborou o ajustamento deste modelo através dos pesos factoriais e dos valores considerados aceitáveis dos índices de ajustamento. Por acréscimo, a análise da consistência interna em ambos os estudos revelou valores aceitáveis do *alpha* de Cronbach para os três factores.

Os três factores apurados são consistentes com a literatura existente e agrupam itens referentes a tipologias semelhantes de métodos, nomeadamente quanto à sua organização de acordo com a gravidade dos comportamentos (Croyle & Waltz, 2007; Skegg, 2005; Whitlock et al., 2008). Assim, se perspectivarmos os comportamentos auto-lesivos numa linha contínua de gravidade, podemos considerar que o Factor II (*Comportamentos Auto-Lesivos Leves/Moderados)* se posicionará no início/meio desse *continuum*, enquanto o Factor I (*Comportamentos Auto-Lesivos Severos e Tentativas de Suicídio*) se situará num ponto mais extremo do mesmo, englobando já os actos suicidários. Concomitantemente, a análise factorial confirmatória revelou que estes factores se correlacionavam negativamente.

No que respeita ao Factor III (*Consumo de Substâncias Psicoactivas*), este factor engloba comportamentos considerados socialmente aceites e típicos da adolescência (e.g. Degenhardt et al., 2008; Matos et al., 2012; Zappe & Dell'Aglio, 2016). No entanto, neste contexto o consumo de álcool e de outras substâncias psicoactivas tem subjacente uma intenção auto-agressiva que o distancia dos consumos considerados "normais". Torna-se, contudo, difícil de argumentar onde este factor se poderá posicionar no *continuum* em termos de gravidade. Tendo também em conta os valores correlacionais positivos deste factor com os factores I e II, uma hipótese que colocamos é se o consumo de substâncias psicoactivas

poderá acompanhar outros comportamentos auto-lesivos, ou se poderá funcionar como uma "porta de entrada" para comportamentos auto-lesivos considerados mais graves.

O conhecimento desta organização factorial dos comportamentos auto-lesivos poderá ter implicações no âmbito clínico. Para além de contribuir para a sensibilização quanto à existência de um *continuum* auto-lesivo em que comportamentos menos graves poderão levar à prática de comportamentos mais severos, a sua utilização poderá promover o aprofundamento da prática destes comportamentos. A utilização clínica do ICAL pode, deste modo, ser relevante para a sinalização de adolescentes em risco de iniciar comportamentos auto-lesivos mais graves, como tentativas de suicídio. Especificamente o factor II, relativo ao consumo de substâncias psicoactivas, poderá permitir uma nova abordagem aos adolescentes que apresentem estes consumos, no sentido de averiguar se estes têm um intuito auto-agressivo subjacente.

Em termos investigacionais, os resultados apresentados demonstram que o ICAL poderá ser uma importante ferramenta para o estudo dos comportamentos auto-lesivos, particularmente no âmbito da sua possível correlação com outros fenómenos. Assim, a apresentação de múltiplos métodos auto-lesivos, a categorização da sua frequência, e o seu agrupamento factorial num só instrumento poderão contribuir para o aprofundamento da literatura nesta área.

Em suma, os resultados obtidos no presente estudo permitem-nos concluir que o ICAL apresenta uma estrutura relativamente sólida e assente em características psicométricas aceitáveis, o que possibilita a sua aplicação na população adolescente Portuguesa. De igual modo, a estrutura factorial encontrada permite a exploração de diferentes tipologias de métodos auto-lesivos. No entanto, este estudo apresenta algumas limitações, nomeadamente quanto à dimensão da amostra e suas especificidades (como o tipo de população). É igualmente necessária a realização de estudos posteriores que analisem a validade convergente e discriminante, e que confirmem a estabilidade da estrutura factorial encontrada.

Espera-se que o ICAL seja passível de ser utilizado quer na clínica, quer no âmbito de investigações futuras, permitindo não só a replicação e confirmação dos resultados obtidos, como também o aprofundamento do conhecimento sobre o fenómeno dos comportamentos auto-lesivos.

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Social Representations about the Functions of Deliberate Self-Harm from Adults and Adolescents: A Qualitative Study*

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Abstract

This study aimed to describe the social representations about the functions of deliberate self-harm and to compare these representations from adolescents with and without a history of deliberate self-harm and adults without these behaviours.

We conducted a qualitative study involving the thematic analysis of forty-one semistructured interviews. The participants consisted of 11 adolescents with a history of deliberate self-harm, 15 adolescents without deliberate self-harm and 15 adults also without these behaviours.

The interviewees mentioned eight functions of deliberate self-harm consistent with the existing literature, namely interpersonal functions (*Communication Attempt*, *Interpersonal Boundaries*, *Interpersonal Influence*, *Peer Bondin*g) and intrapersonal functions (*Affect Regulation*, *Anti-Dissociation, Escape Mechanism* and *Self-Punishment*). Also, two new functions not described in the literature were mentioned (*Introspective Mechanism* and *Replacement of Suffering*). Regarding the differences between the three groups, several disparities emerged. Overall, results revealed that the group of adults referenced more interpersonal functions, while both groups of adolescents gave more relevance to intrapersonal functions.

This study provides insight regarding the social representations about the functions of deliberate self-harm, also focusing on the differences between adolescents with and without these behaviours and adults without deliberate self-harm.

Keywords: Deliberate Self-Harm; Social Representations; Functions; Interviews; Qualitative Study

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* Paper submitted to the journal *Advances in Mental Health*

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Introduction

Deliberate self-harm is considered a public health problem (Hawton, Saunders, & O'Connor, 2012), affecting mainly adolescents and young adults. In Portugal, where this study was conducted, it is estimated that its prevalence among adolescents oscillates between 7.3% and 28% (Gonçalves, Martins, Rosendo, Machado & Silva, 2012; Gouveia-Pereira, Gomes, Santos, Frazão & Sampaio, 2016; Guerreiro, Sampaio, Figueira & Madge, 2017). This prevalence is similar to those found in other countries (Brunner et al., 2013; Muehlenkamp, Claes, Havertape & Plener, 2012).

There have been some conceptual problems surrounding the definition of these behaviours. In the present study, we follow the definition stipulated in the Child and Adolescent Self-Harm in Europe (CASE) Study (Madge et al., 2008) and in the National Plan for Suicide Prevention in Portugal (Plano Nacional de Prevenção do Suicídio, Carvalho et al., 2013). Hence, deliberate self-harm refers to behaviours with or without suicidal intent and includes self-cutting, self-burning, self-hitting, jumping from high places, ingesting pharmaceuticals in higher doses than the therapeutic recommendations, amongst other behaviours.

Apart from the attention this phenomenon has been receiving from the scientific field, there is also growing visibility of deliberate self-harm in the general media (Swannell et al., 2010; Trewavas, Hasking & McAllister, 2010; Whitlock, Powers & Eckenrode, 2006; Whitlock, Purington & Gershkovich, 2009), particularly in social media (Niwa & Mandrusiak, 2012; Reddy, Rokito & Whitlock, 2016; Zdanow & Wright, 2012). The normalization of this behaviour in the media may help those who engage in self-harm feel less isolated, but it may also increase interest in trying or adopting this practice as a way of coping with stress or distress (Reddy et al., 2016). Likewise, this visibility can confront the general public with the existence of this phenomenon and subsequently build and modify their social representations about it, regardless of not having personal contacts with deliberate self-harm. In addition, the high prevalence rates of deliberate self-harm may imply that more individuals are aware of this behaviour (for example parents, teachers or peers) and, as a consequence, build social representations about this phenomenon.

Research has shown that deliberate self-harm can have several functions (e.g. Nock, 2009). Klonsky and Glenn (2009) systematized many of these functions in their Inventory of Statements about Self-Injury which includes a scale that evaluates 13 types of functions of deliberate self-harm that aggregate in two dimensions. These dimensions include interpersonal functions (autonomy, interpersonal boundaries, interpersonal influence, peer bonding, revenge, self-care, sensation seeking, and toughness) and intrapersonal functions

(affect regulation, anti-dissociation, anti-suicide, marking distress, and self-punishment). The interpersonal functions of deliberate self-harm can serve as a signal of distress that is reinforced by the caregiving behaviour it elicits from others, and also as a signal of strength that is reinforced by warding off potential threats and that can strengthen affiliation with others (Nock, 2008). Understanding the motivations for these behaviours is crucial for supportive and effective responses to individuals' disclosures of self-harm (Muehlenkamp, Brausch, Quigley & Whitlock, 2013). Furthermore, knowing how this phenomenon is viewed by others may have important implications for clinical intervention and prevention programs (Bresin, Sand & Gordon, 2013). Hence, analyzing the representations about the functions of deliberate self-harm of subjects with and without these behaviours is relevant.

The importance of exploring and describing people's representations and attitudes towards deliberate self-harm has been recognized and some studies have focused on this topic. Most of the existing studies focus on the description of the attitudes and experiences of different types of populations, namely adolescents who self-harm (Batejan, Swenson, Jarvi & Muehlenkamp, 2015; Klineberg, Kelly, Stansfeld & Bhui, 2013; Rissanen, Kylmä & Laukkanen, 2008), parents of adolescents who self-harm (Ferrey et al., 2016; McDonald, O'Brien & Jackson, 2007; Oldershaw, Richards, Simic & Schmidt, 2008; Rissanen, Kylmä & Laukkanen, 2009), peers (Bresin et al., 2013), healthcare professionals (Karman, Kool, Poslawsky & Van Meijel, 2015; McHale & Felton, 2010; Rees, Rapport, Thomas, John & Snooks, 2014), counsellors (De Stefano, Atkins, Noble & Heath, 2012; Fox, 2011; Long & Jenkins, 2010), teachers (Berger, Hasking, Reupert, 2014; Heath, Toste & Beettam, 2007; Heath, Toste, Sornberger & Wagner, 2011), and others.

However, there is still a general lack of knowledge concerning the social representations about the functions of deliberate self-harm, since a considerable part of research focused only on the attitudes towards self-harm. Moreover, there is limited information regarding the perspectives of individuals that did not have direct contact with these behaviours (professionally or personally). In addition, there are no studies that compared the social representations of diverse populations and their possible divergences, including the social representations about the functions of these behaviours. One exception is the quantitative study developed by Batejan and colleagues (2015), which compared the views about the functions of deliberate self-harm from college students with and without a history of these behaviours. The authors utilized the Inventory of Statements About Self-Injury, which was completed by college students. Their results revealed that the participants without a history of self-harm appeared to emphasize some interpersonal functions slightly more than participants with a history of self-injury.

Specifically in Portugal, as far as we know there are no studies that explored the representations about the functions of deliberate self-harm. Thus, our study aimed to qualitatively describe the social representations about the functions of deliberate self-harm from adolescents with and without an history of deliberate self-harm and adults without these behaviours, and to compare the social representations of these three groups.

Methods

Participants

In total, our sample comprised 41 participants which were organized into three distinct groups: 11 adolescents with a history of deliberate self-harm, 15 adolescents without a history of deliberate self-harm, and 15 adults also without a history of these behaviours. For this study, we did not involve adults with deliberate self-harm since these behaviours are considerably less frequent in adults, with a lifetime prevalence of 5.9% and a 12 month prevalence of 0.9% (Klonsky, 2011).

The interviewees lived in the centre region of Portugal. The group of adolescents with a history of deliberate self-harm comprised 11 participants, eight females and three males, with ages ranging from 14 to 19 years old (M = 16.7). The group of adolescents without a history of deliberate self-harm consisted of 15 participants, eight females and seven males, with ages between 14 and 18 years old (M = 15.9). At last, the group of adults without a history of deliberate self-harm comprised 15 participants, seven females and eight males, with ages ranging from 33 to 65 years old (M = 45.7).

Regarding having interpersonal contacts with individuals who have self-harmed, 24 participants reported knowing one or more person with these behaviours: all the 11 adolescents with deliberate self-harm, six adolescents without deliberate self-harm and seven adults. It is important to note that all of the adolescents with deliberate self-harm revealed that they knew other self-harmers and most of them reported having close friends who also presented these behaviours.

Table 1. Age of onset, gender and methods used for deliberate self-harm (N=11)

Age of Onset	Gender	Methods
12	Female	Cutting
12	Female	Cutting
12	Female	Cutting, Drinking and Ingesting Medication
12	Female	Biting and Banging or Hitting Self
13	Female	Cutting
13	Female	Cutting and Burning
14	Female	Cutting
14	Male	Cutting
15	Female	Cutting
15	Male	Cutting
16	Male	Cutting and Burning

Instruments

The instruments used in the present study comprised a set of brief socio-demographic questions (made after the interview) and a semi-structured interview script. The interview script was designed to obtain information regarding the representations about the functions of deliberate self-harm. The main goal was to allow participants to talk freely about their experiences, thoughts and opinions, but there was also the concern to elicit information about this topic. Therefore, the script included open-ended questions and possible follow-up questions (Dörnyei, 2007) which were framed according to information from the literature (Klonsky, 2007; Nock, 2009). Providing some examples, the interview script included questions such as “Please share what you think about these behaviours...”, “What do you think that might get young people to self-harm...” and “What reasons exist for young people to engage in deliberate self-harm? Please share your thoughts...”.

Procedure

The participants were recruited through contacts with one school and personal contacts who then snowballed into other connections. The potential participants were contacted by telephone or email and informed about the study purpose. Those who agreed to participate were then given more detail about the investigation and a meeting was arranged to perform the interview according to their availability. Prior to the interview, each participant was guaranteed anonymity and asked to sign a consent form. Regarding adolescents, their parents were responsible for signing the consent form after being informed about the study. All the parents had previous knowledge of their children deliberate self-harm.

The interviews were conducted between September 2015 and August 2016 and had an average duration of 30 minutes. After the interviews, the participants were asked if they had any doubts about the study. The audio from the interviews was recorded with permission and later transcribed. The 41 transcripts which constituted the data were then imported into QSR International NVivo8 software for further analysis.

Data Analysis

In accordance with the aims of this study, content analysis was used in an inductive approach, particularly due to the fact that it is considered an appropriate analysis in qualitative descriptive studies (Sandelowski, 2000; Vaismoradi, Jones, Turunen & Snelgrove, 2016; Vaismoradi, Turunen & Bondas, 2013). In a first moment, the transcripts were comprehensively read to understand what the participants told regarding deliberate self-harm and what were the emerging categories. Afterwards, all the statements about the subject were coded and sorted into categories based on how different codes were related and linked (Hsieh & Shannon, 2005).

Results

Several functions emerged from the content analysis of the 41 interviews. In total, participants made references to 10 functions that we organized into interpersonal and intrapersonal functions according to their nature.

The interpersonal functions include Communication Attempt (to communicate with others), Interpersonal Boundaries (to establish a distinction between self and other), Interpersonal Influence (to manipulate others or seek help) and Peer Bonding (to establish a connection with peers). The intrapersonal functions include Affect Regulation (to alleviate negative affect or to create positive affect), Anti-Dissociation (to end the experience of dissociation), Escape Mechanism (to escape from or to ignore problems), Introspective Mechanism (to concentrate on thoughts), Replacement of Suffering (to replace emotional distress with physical pain), and Self-Punishment (to express anger towards oneself). Since the verbalization regarding these functions proved to be quite diverse and distinct from the clinical discourse, table 2 presents some excerpts from the interviews.

Table 2. Functions that emerged from content analysis and excerpts from the interviews

	Interpersonal Functions
Communication Attempt	"It is like they are trying to communicate something to the world" "They are saying something through self-harm, something that they can not say otherwise"
Interpersonal Boundaries	"They want to differentiate themselves from schoolmates" "Self-harm implies an enormous tendency for self-affirmation"
Interpersonal Influence	"It is a way to make their family and friends understand they are not alright and that they need to do something" "It seems like a call, a scream, a call for attention, like, 'look at me!'"
Peer Bonding	"It is a form to get integrated with other adolescents" "They want to belong to some kind of adolescent thing"
	Intrapersonal Functions
Affect Regulation	"Not all people do it because it hurts, because of the emotional part, I think of it as the release of their negative energies" "It is the way out, it is the way to relieve their bad feelings" "They feel such great pain that they want to relieve it through cutting"
Anti-Dissociation	"Because they want to feel something" "They need to feel alive"
Escape Mechanism	"They self-harm because there is something wrong and they need to escape from it" "It is the only way to run away from something, from all the problems"
Introspective Mechanism	"Maybe they do it to imagine other things, to put your head in other worlds, in your own thoughts" "I mutilate myself in an introspective way because it helps me to think and connect many ideas when I do it"
Replacement of Suffering	"They are creating a physical pain to forget a psychological pain" "I am substituting the soul's pain by the body pain"
Self-Punishment	"Those kids mutilate because they feel they made mistakes" "They mutilate as punishment" "Instead of taking revenge on others, they blame themselves"

In total, from content analysis emerged 237 references to the functions of deliberate self-harm: 94 (39.7%) referring to interpersonal functions and 143 (60.3%) to intrapersonal functions. In table 3 we detail the number of participants that mentioned the functions in each group, the number of references that each group made to the functions, and the totals for each function.

Table 3. Number of participants who mentioned the function and frequency of references

	Adolescents With DSH (n=11)		Adolescents Without DSH (n=15)		Adults Without DSH (n=15)		Total (N=41)	
	Part.	Ref.	Part.	Ref.	Part.	Ref.	Part.	Ref.
Interpersonal Functions								94
Communication Attempt	-	-	**2**	3	**3**	6	**5**	9
Interpersonal Boundaries	-	-	-	-	**3**	10	**3**	10
Interpersonal Influence	**4**	11	**8**	26	**11**	34	**23**	71
Peer Bonding	-	-	-	-	**3**	4	**3**	4
Intrapersonal Functions								143
Affect Regulation	**11**	49	**7**	19	**4**	10	**22**	78
Anti-Dissociation	**3**	8	**4**	10	**4**	7	**11**	25
Escape Mechanism	**1**	2	**2**	2	**2**	3	**5**	7
Introspective Mechanism	**2**	6	**1**	1	**-**	-	**3**	7
Replacement of Suffering	**3**	10	**1**	2	**-**	-	**4**	12
Self-Punishment	-	-	**2**	2	**3**	12	**5**	14

Focusing on the interpersonal dimension, our results show that the participants mentioned four distinct interpersonal functions and that there were differences between the three groups. The most prominent function was Interpersonal Influence, with a total of 71 references made by 23 participants, followed by Interpersonal Boundaries (10 references), Communication Attempt (nine references) and Peer Bonding (4 references). In terms of differences between groups, adults made references to all the four interpersonal functions, specially Interpersonal Influence (34 references from 11 participants). The group of adolescents without deliberate self-harm cited two functions, Communication Attempt and Interpersonal Influence, and particularly emphasized this last one with 26 references from eight participants. However, the group of adolescents only mentioned Interpersonal Influence, with 11 references made by four participants.

Regarding the intrapersonal dimension, results revealed six intrapersonal functions and further differences between the three groups. The function with more references was Affect Regulation (78 references made by 22 participants), followed by Anti-Dissociation (25 references), Self-Punishment (14 references), Replacement of Suffering (12 references), Escape Mechanism (seven references), and Introspective Mechanism (seven references). Focusing on the differences between groups, adolescents without deliberate self-harm mentioned all the intrapersonal functions, emphasizing Affect Regulation (19 references),

similarly to adolescents with a history of deliberate self-harm, which mentioned five out of the six functions. The group of adults cited four intrapersonal functions. However, if we observe the number of references made by each group, adolescents with deliberate self-harm made a total of 75 references to the intrapersonal dimension, while adolescents without these behaviours made 36 references and adults made 32 references.

Globally, these results indicate that there are some differences concerning the social representations from the three groups, especially in the interpersonal dimension. Results will be further discussed taking into account the contents of the interviews.

Discussion

This study aimed to contribute to the understanding of the social representations about the functions of deliberate self-harm, using a qualitative approach. We also intended to explore the differences between the representations of adolescents with and without deliberate self-harm and adults without these behaviours.

Previous to content analysis, the socio-demographic data allowed us to gain some insight into the participants' interpersonal contacts with individuals who have self-harmed. It is important to stress that all of the adolescents with deliberate self-harm stated that they knew or were close friends with other self-harmers, while only six adolescents and seven adults without deliberate self-harm had interpersonal contacts with a history of these behaviours. Some studies have found that self-harmers know more peers who self-harm than non-harmers (Claes, Houben, Vandereycken, Bijttebier & Muehlenkamp, 2010), including friends (Nock & Prinstein, 2005; Yates, Carlson & Egelang, 2008). Hence, we consider that this data may be associated with the influence that peers have in the onset of these behaviours (Jarvi, Jackson, Swenson, Crawford, 2013). In terms of the interpersonal contacts of adolescents without deliberate self-harm, our findings are also consistent with previous research (Bresin et al., 2013). Nonetheless, this result shows that more than half of the adolescents and adults without deliberate self-harm build their representations based on other “sources” besides personal contacts with experiences of these behaviours, such as information presented in the media.

Overall, the participants cited 10 different types of functions, with some differences in the three groups (further explained). The interpersonal functions included Communication Attempt, Interpersonal Boundaries, Interpersonal Influence and Peer Bonding; while the intrapersonal functions included Affect Regulation, Anti-Dissociation, Escape Mechanism, Introspective Mechanism, Replacement of Suffering and Self-Punishment. Comparing these functions with the organization proposed by Klonsky and Glenn (2009), only six of the thirteen functions proposed by the authors were cited by the participants. Regarding the

interpersonal dimension, the participants did not mention Autonomy, Revenge, Self-Care, Sensation Seeking and Toughness. Focusing on the intrapersonal dimension, Anti-Suicide and Marking Distress were also not mentioned. These results may indicate that there is still a general lack of scientific knowledge about the functions of deliberate self-harm. Nonetheless, two functions not mentioned in this systematization emerged from content analysis (Communication Attempt and Escape Mechanism), as well as two new functions which are not found in the literature (Introspective Mechanism and Replacement of Suffering).

Focusing on these four functions, Communication Attempt has been mentioned by some authors (e.g. Conterio & Lader, 1998; Favazza, 1987) but it was not present in Klonsky and Glenn's categorization (2009). Regarding Escape Mechanism, although it can be considered a form of Affect Regulation because it involves the reducing of negative states (Klonsky, 2007), the interviewees' verbalizations of this function implied the specific escape of problems and their ignoring, therefore we opted by considering it an independent function. Likewise, the function Replacement of Suffering has some similarities with Marking Distress because both of them involve the physical expression of negative emotions. However, we decided to differentiate these functions, since Replacement of Suffering consists of a specific mechanism where emotional distress is replaced by physical pain. At last, we did not find any references to the function Introspective Mechanism nor to the contents associated with it.

Regarding the disparities between the three groups of participants, there are some differences that should be noted. Overall, the group of adults referenced more interpersonal functions, while the groups of adolescents with and without deliberate self-harm gave more relevance to intrapersonal functions. These results regarding the functions are similar to those found in the study of Batejan and colleagues (2015), where participants without deliberate self-harm considered interpersonal functions for engaging in these behaviours as more relevant than participants with self-harm did.

In the present study, adults were the only group that mentioned the interpersonal functions Interpersonal Boundaries and Peer Bonding, and greatly emphasized Interpersonal Influence. Moreover, the interviewees' discourses about Interpersonal Influence, were oriented towards two distinct approaches. Adolescents with self-harm described this function as a help-seeking behaviour while adults without deliberate self-harm tended to view this function as a negative call for attention from the self-harmer. On the other hand, adolescents without deliberate self-harm verbalized both types of perspectives concerning this function. These findings may suggest that, as Law, Rostill-Brookes and Goodman (2009) found in their study, there is still the stigma and social belief that these behaviours have a manipulatory nature. We hypothesize that this stereotypical perspective has influenced parents' social representations.

Subsequently, when comparing these results with the perspectives of parents of self-harmers some similarities emerge, such as the description of deliberate self-harm as a "time-limited phase", influenced by peers, and sometimes seen as a "fashion" (Oldershaw et al., 2008). In this study, authors also found that all parents felt that they could not fully understand or empathise with self-harm, which most adults also stated in our interviews. These similarities between the representations of adults without interpersonal contacts with deliberate self-harm and parents of adolescents who self-harmed may imply that these social representations are build regardless of having contact with these behaviours.

Nonetheless, the fact that this group of adolescents without self-harm also emphasized Interpersonal Influence as a help-seeking function and cited all the functions that self-harmers mentioned, might indicate that age proximity can play a role in the understanding of these behaviours. Therefore, peers seemed to be more aware of the functions of deliberate self-harm, which is not in accordance with previous research that concluded that peers were largely unclear about why people engage in these behaviours (Bresin et al., 2013). However, this discrepancy can be related to the methods used in the studies, since we followed a qualitative approach that allowed participants to talk freely, while the mentioned study was based on the reading of fictional vignettes. Furthermore, we hypothesize that, since six adolescents without deliberate reported knowing other adolescents with these behaviours, their social representations might have been influenced by the sharing of experiences from their peers, hence the references to intrapersonal functions.

On the other hand, the focus of adolescents who self-harmed on intrapersonal functions is also important and consistent with previous research (e.g. Klonsky, 2007). It is clear that this group of participants emphasized this type of functions, specially Affect Regulation. It is possible to conclude that these adolescents' social representations about self-harm – and, of course, their own experiences – are based on the idea that self-harm is a lonely and autonomous way of coping with negative emotional states (Affect Regulation), avoiding dissociative states (Anti-Dissociation), escaping and withdrawing from negative emotions (Escape Mechanism) and isolating themselves in their thoughts (Introspective Mechanism). When we take into consideration that the other function that this group mentioned consisted in Interpersonal Influence (as a help-seeking behaviour), we might also question if, on their perspective, when self-harm is directed towards others, it encompasses a cry for help, as if their distress has become too unbearable to deal on their own through intrapersonal functions.

In summary, our study provides relevant information regarding the social representations about the functions of deliberate self-harm in adolescents and its differences in the three groups of participants. First of all, we must underline the presence of two new

functions not described in the literature, which can contribute to further understanding about the motivations of deliberate self-harm. Secondly, the differences found between the three groups of interviewees revealed that there is a gap between the representations of adults without deliberate self-harm and the representations of adolescents with and without these behaviours. Clinically, the fact that peers were more aware of the functions of these behaviours is relevant, since it indicates that friends and close peers can play a significant role in clinical work (Bresin et al., 2013). Also, our results underline the need to psychoeducate parents and other adults potentially involved in clinical interventions (such as other family members, teachers or healthcare workers), considering their social representations about this phenomenon are sometimes biased and can have negative effects on treatment and recovery. In this sense, our findings suggest that there is the need to develop prevention programs focusing on deliberate self-harm, namely through psychoeducation. This approach might be important to contribute to the building and modification of representations and to avoid subsequent negative attitudes towards adolescents who engage in deliberate self-harm.

Limitations and Directions for Future Research

Although the qualitative methods used in the current study allow a comprehensive approach to this subject, certain limitations should be noted. First of all, this study was limited by its sample size and the selection of the participants was mostly made through personal contacts, consisting of a convenience sample. A larger sample, with more diversity, would allow more representative results.

Our findings offer some important insight concerning the social representations about the functions of deliberate self-harm, but more research is clearly needed in this area. In a first stance, since there is still scarce information regarding the social representations of individuals that did not have direct contact with these behaviours, future research could involve the comparative study of the representations about the functions of deliberate self-harm in different social groups. This could include individuals from different ethnic groups, with different professional backgrounds (such as education staff, or mental health workers), with distinct “proximities” to deliberate self-harm (namely the families of those who present these behaviours), amongst others. Furthermore, other social representations about the phenomenon of deliberate self-harm could be explored.

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Representations about the Functions of Deliberate Self-Harm: Construction and Validation of a Questionnaire for Portuguese Adolescents*

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Abstract

With the increased awareness about deliberate self-harm, the understanding of its representations can be important for clinical intervention and prevention. However, there is still a lack of instruments to assess the representations about the functions of these behaviours.

The present research focuses on the validation of the Questionnaire of Representations about the Functions of Deliberate Self-Harm for adolescents. The basis for this questionnaire was the translation and adaptation of the Inventory of Statements About Self-Injury. In order to access people's representations, we conducted semi-directive interviews with adolescents with and without deliberate self-harm, as well as an analysis of the Portuguese written press. The results of these studies complemented the questionnaire with new functions and items.

Study 1 consisted of an exploratory factor analysis with a sample of 434 adolescents. Results revealed a two-factor structure of interpersonal and intrapersonal dimensions. After item reduction, the factorial analysis of the independent functions showed acceptable psychometric values. This structure was corroborated in Study 2 by a confirmatory factor analysis with a new sample of 405 adolescents, which revealed an acceptable model fit.

This questionnaire presents a relatively solid structure and is based on acceptable psychometric properties, which allows its use in future research.

Keywords: Deliberate Self-Harm; Adolescence; Questionnaire; Validation; Factor Analysis

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* Paper *in press* in the *Journal of Personality Assessment*

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Introduction

Deliberate self-harm is nowadays considered a public health concern and has become more prevalent among adolescents (e.g. Hawton, Saunders & O'Connor, 2012). This phenomenon includes a range of self-aggressive behaviours, irrespective of motives or the extent of suicidal intent (Guerreiro, Sampaio, Figueira & Madge, 2017; Hawton et al., 2012; Madge et al., 2008). In Portugal, the prevalence of deliberate self-harm stands between 7.3% and 28% (Gonçalves, Martins, Rosendo, Machado & Silva, 2012; Guerreiro et al., 2017; Gouveia-Pereira, Gomes, Santos, Frazão & Sampaio, 2016), similarly to other countries (Brunner et al., 2013; Muehlenkamp, Claes, Havertap & Plener, 2012).

Along with the crescent awareness of deliberate self-harm among adolescents, there is also growing visibility of these behaviours in the general media and internet (Niwa & Mandrusiak, 2012; Reddy, Rokito & Whitlock, 2016; Swannell et al., 2010; Trewavas, Hasking & McAllister, 2010; Whitlock, Powers & Eckenrode, 2006; Whitlock, Purington & Gershkovich, 2009; Zdanow & Wright, 2012). Nonetheless, as Whitlock et al. (2009) mentioned, though media representations of deliberate self-harm are increasingly present and available, it is not clear to what extent these representations influence the behaviours of viewers. For example, it may help those who engage in self-harm feel less isolated, but it may also increase the interest in trying or adopting these behaviours as a way of coping with stress or distress (Reddy et al., 2016).

Understanding how this phenomenon is viewed by others may have important implications for clinical intervention and prevention programs (Bresin, Sand & Gordon, 2013). For instance, if friends and family members have an inaccurate understanding of the functions of deliberate self-harm (e.g., believing the behaviour to be an act of manipulation instead of support-seeking), it may lead to responses that inadvertently exacerbate the frequency and severity of the behaviours (Bresin et al., 2013). Thus, knowing and understanding the representations about the functions of deliberate self-harm is quite relevant, including the representations of those who did not have direct contact with these behaviours.

Some studies have explored and described the perceptions and attitudes towards deliberate self-harm. Most of the existing literature has focused on the perspectives of adults, including parents of self-harmers (Ferrey et al., 2016; McDonald, O'Brien & Jackson, 2007; Oldershaw, Richards, Simie & Schmidt, 2008), healthcare professionals (Karman, Kool, Poslawsky & Van Meijel, 2015; Lindgren, Oster, Aström & Graneheim, 2011; McHale & Felton, 2010; Rees, Rapport, Thomas, John & Snooks, 2014), counsellors (De Stefano,

Atkins, Noble & Heath, 2012; Fox, 2011; Long & Jenkins, 2010), and teachers (Berger, Hasking & Reupert, 2014; Heath, Toste & Beettam, 2007; Heath, Toste, Sornberger & Wagner, 2011). The studies that focused on adolescents' perceptions and attitudes about deliberate self-harm mostly used samples of participants who had a history of these behaviours (Klineberg, Kelly, Stansfeld & Kamaldeep, 2013; Rissanen, Kylmä & Laukkanen, 2008). However, some studies also involved adolescents without deliberate self-harm (Batejan, Swenson, Jarvi & Muehlenkamp, 2015; Bresin et al., 2013).

There are several limitations to the current knowledge about the representations of deliberate self-harm. First of all, most studies are focused on adults' attitudes and not on their representations. Secondly, a great part of research is based on samples that had some type of direct contact with deliberate self-harm. Lastly, most research utilized qualitative designs, which allows more comprehensive results but also limits their scope and generalization. Considering these factors, it is important to develop a questionnaire to assess the representations about the functions of deliberate self-harm. Therefore, the main objective of this paper was to create an instrument aimed at adolescents with and without direct contact with deliberate self-harm.

Although there are several instruments that analyse deliberate self-harm, as far as we know there are no instruments exclusively dedicated to the study of the representations about the functions of these behaviours. In terms of instruments, the previously mentioned studies that focused on the views of adolescents without deliberate self-harm utilized fictional vignettes (Bresin et al., 2013) and the Inventory of Statements About Self-Injury (Batejan et al., 2015). Nonetheless, this inventory is not an instrument aimed at the study of the representations of this phenomenon. The Inventory of Statements About Self-Injury (ISAS) was developed by Klonsky & Glenn (2008) and comprises two distinct components. The first section is a list of several methods of deliberate self-harm. The second section is a scale that evaluates 13 types of functions of these behaviours (e.g. affect regulation, anti-dissociation or interpersonal influence) that aggregate in two dimensions (intrapersonal and interpersonal functions). This section should only be completed by respondents who have a history of deliberate self-harm.

Since the ISAS was previously employed in this research area (Batejan et al., 2015) and taking into account the variety of functions it assesses, the translation and adaptation of its second section was the basis for the development of our questionnaire. However, as formerly stated, the ISAS was originally aimed to be answered by adolescents who have a

history of deliberate self-harm. Hence, there was the need to complement the inventory's contents according to the representations of non self-harmers and the representations of Portuguese adolescent self-harmers. For this purpose, two additional studies were conducted (detailed in the questionnaire development section). The results obtained from these studies allowed us to add more items and functions to the questionnaire.

In this article, we present two studies that analysed the psychometric characteristics of our questionnaire (Questionnaire of Representations About the Functions of Deliberate Self-Harm, QRFDSH) in a sample of Portuguese adolescents. We intended to test the factorial structure of this instrument considering the two dimensions (interpersonal and intrapersonal) and the independent functions. In the first study, we conducted an exploratory factor analysis of the functions of deliberate self-harm and the interpersonal and intrapersonal dimensions. This process also allowed us to reduce the instrument through a process of item elimination. The factorial structure of the reduced questionnaire was then evaluated in Study 2 with an independent sample. The internal consistency of the QRFDSH was also tested.

Questionnaire Development

The QRFDSH incorporates items from three different sources: the translation of the ISAS (Klonsky & Glenn, 2008), items that resulted from the analysis of interviews and items that emerged from the analysis of Portuguese written press.

Translation and Adaptation of the Inventory of Statements About Self-Injury

The first step in the construction of the questionnaire was the translation and adaptation of the ISAS. The first section of this instrument (i.e. inventory of deliberate self-harm behaviours), has been validated to Portuguese adolescents (Duarte, Gouveia-Pereira & Sampaio, in press-a).

The second section of the ISAS, about the functions of these behaviours, is composed of 39 items that characterize 13 functions of deliberate self-harm. These functions can be organized in two dimensions. The interpersonal dimension, including eight subscales: *Autonomy*, *Interpersonal Boundaries*, *Interpersonal Influence*, *Peer Bonding*, *Revenge*, *Self-Care*, *Sensation Seeking* and *Toughness*. The intrapersonal dimension, including five subscales: *Affect Regulation*, *Anti-Dissociation*, *Anti-Suicide*, *Marking Distress*, and *Self-Punishment*.

Overall, the ISAS has demonstrated good psychometric properties. The second section of this instrument has revealed good internal consistency, with total values of Cronbach's Alpha of .93 (Bildik, Somer, Kabukçu-Başay, Başay & Özbaran, 2013) and Cronbach's Alpha for the interpersonal and intrapersonal scales of .88 and .80, respectively (Klonsky & Glenn, 2008). It has also shown good test-retest reliability, with correlations of .60 for the intrapersonal functions, .82 for the interpersonal functions, and values between .35 and .89 regarding individual functions (Glenn & Klonsky, 2011). The theorised two-factor structure (i.e. interpersonal and intrapersonal dimensions) has also been demonstrated in the literature (Klonsky, Glenn, Styer, Olino & Washburn, 2015; Kortge, Meade & Tennant, 2013).

Regarding the translation of this scale, we contacted six psychologists with knowledge about deliberate self-harm and fluent in English. Three psychologists translated the original items to Portuguese. Subsequently, three different psychologists retro-translated these items into English. The final versions resulting from this process were compared with the original instrument and the most similar items were selected.

Analysis of Semi-Directive Interviews

This study was based on a qualitative analysis of the representations about the functions of deliberate self-harm from adolescents (Duarte, Gouveia-Pereira & Sampaio, in press-b). The sample comprised 26 participants: 11 adolescents with a history of deliberate self-harm and 15 adolescents without deliberate self-harm. The participants were recruited through contacts with one school and several personal contacts that snowballed into other connections.

The script of the semi-structured interview was designed according to the literature. Using content analysis' procedures, the statements were coded and sorted into categories based on how different codes/statements were related and linked (Hsieh & Shannon, 2005). Subsequently, the categories with more than two codes were selected and the corresponding statements were converted into items. As it is visible in Table 3, new functions emerged from the results of this analysis (*Communication Attempt*, *Escape Mechanism*, *Introspective Mechanism*, and *Replacement of Suffering*), as well as several new items that complement the existing functions.

Analysis of the Portuguese Written Press

In this analysis, we considered published news during an 11-year period (between January 2004 and December 2015) in seven different Portuguese generalist publications (five newspapers and two magazines). Using 18 search terms associated with deliberate self-harm, we collected a total of 639 news. Content analysis procedures were used and the text was divided into categories that corresponded to the functions present in the ISAS. This analysis allowed the formulation new items that complemented several functions from the original questionnaire.

Final Structure of the QRFDSH

In summary, 36 new items emerged from the interviews and written press analyses. Of this total, 16 items complemented the functions from the ISAS and 20 corresponded to four new functions (Table 1). Therefore, this first version of the QRFDSH is composed of 17 functions of deliberate self-harm and 75 items.

Table 1. Structure of the QRFDSH with the new functions and new items

Dimension	Function	Number of Original Items	Number of New Items
Interpersonal	Autonomy	3	0
	Communication Attempt *	0	5
	Interpersonal Boundaries	3	2
	Interpersonal Influence	3	4
	Peer Bonding	3	1
	Revenge	2	2
	Self-Care	3	0
	Sensation Seeking	3	0
	Toughness	3	0
Intrapersonal	Affect Regulation	3	2
	Anti-Dissociation	3	2
	Anti-Suicide	3	0
	Escape Mechanism *	0	5
	Introspective Mechanism *	0	5
	Marking Distress	3	0
	Replacement of Suffering *	0	5
	Self-Punishment	4	3

Note: * – New functions.

Study 1: Exploratory Factor Analysis

Method

Participants.

The initial sample included 452 students from three public schools located in the districts of Lisbon and Leiria.

In dealing with missing values, the Little's MCAR test showed that the missing values were not random ($\chi^2_{(1032)} = 1160.248$, $p < .01$). Thus, it was not possible to carry out the imputation process and the 18 subjects with missing values were removed from our sample. Therefore, the sample was comprised of 434 subjects.

From this total, 226 (52.1%) participants were female and 208 (47.9%) were male. Their ages ranged from 12 to 18 years old, with a mean of 15.6 years (SD=1.5). Participants frequented the 7th grade (6%), 8th grade (12.9%), 9th grade (5.8%), 10th (36.2%), 11th grade (26.5%), and 12th grade (12.7%). Regarding the participants' family, 52.4% lived with their parents and siblings, 21.1% lived with their parents, 18.1% lived with their mother, 4.4% lived with one of their parents and their stepmother/stepfather, 2.1% lived with their father, and 1.9% lived with other people.

Measures.

The instruments used in the present study consisted of the first version of the QRFDSH and a brief socio-demographic questionnaire. The QRFDSH included a short introduction mentioning that some adolescents may show deliberate self-harm, followed by some examples of these behaviours. Taking into account that the questionnaire will also be answered by non self-harmers, the initial sentence of the ISAS (“When I self-harm, I am...”) was changed to “When young people have these behaviours, they are...”. Additionally, in order to allow more detailed data we reorganized the answers on a five point Likert scale, referring to the degree of accordance with each item: totally disagree, disagree, neither, agree, or totally agree.

The socio-demographic questionnaire included questions about the participants' gender, age, school grade, and household.

Procedures.

Before data collection, we asked a group of adolescents to complete the questionnaire and share any doubts about it, in order to confirm the instrument was easily comprehended.

Several schools were contacted and informed about the objectives of the present investigation. After receiving the schools' administration authorisation, several classes were randomly selected and the dates for data collection were provided by the director of each class. In a first moment, the researcher delivered the consent forms to the students' parents/legal guardians. In a second moment, the students whose parents/legal guardians signed the consent form completed the questionnaire. The participants were informed that their collaboration was voluntary and that the collected data was anonymous and confidential.

Data Analysis.

All statistical analyses were carried out using SPSS v22 software and Amos Version 22.0 (IBM SPSS, Chicago, IL). We carried out a first Exploratory Factor Analysis (EFA) testing the meta-model of the two functions of deliberate self-harm (i.e., interpersonal and intrapersonal functions). The functions that loaded on each factor were then entered in a twofold EFA, the first with items in the interpersonal functions, and the second with items in the intrapersonal functions. The EFAs were developed with Principal Axis Factoring and Promax with Kaiser Normalization rotation, and items with small factor coefficients (< .40) were removed.

Results

The EFA for the two dimensions of deliberate self-harm provided an unacceptable five-factor solution with eigenvalues higher than 1. After changing this analysis to extract two factors, explaining 49.22% of the variance (KMO = .86, $\chi^2 = 3305.36$, $p < .001$), the functions of *Marking Distress*, *Interpersonal Boundaries*, *Sensation Seeking*, *Peer Bonding*, *Interpersonal Influence*, *Toughness*, *Revenge*, *Autonomy*, and *Communication Attempt* all loaded exclusively on interpersonal functions' factor; while the functions of *Affect Regulation*, *Self-Punishment*, *Anti-Dissociation*, *Introspective Mechanism*, *Replacement of Suffering*, and *Escape Mechanism* loaded exclusively on *Intrapersonal functions factor*; and finally the functions of *Self-Care* and *Anti-Suicide* loaded lower than the threshold in both factors (Table 2).

Table 2. Exploratory factor analysis for the two-factor model

Functions	*M*	*(SD)*	*Factor 1 - Interpersonal*	*Factor 2 - Intrapersonal*
Affect Regulation	3.54	(.81)	-	.69
Self-Punishment	3.43	(.78)	-	.72
Anti-Dissociation	2.95	(.88)	-	.52
Introspective Mechanism	2.97	(.82)	-	.55
Replacement of Suffering	3.57	(1.02)	-	.89
Escape Mechanism	3.45	(.88)	-	.73
Marking Distress	3.03	(.89)	.51	-
Interpersonal Boundaries	2.34	(.70)	.65	-
Sensation Seeking	2.28	(.81)	.64	-
Peer Bonding	1.95	(.77)	.75	-
Interpersonal Influence	2.87	(.81)	.75	-
Toughness	2.64	(.92)	.60	-
Revenge	2.32	(.82)	.59	-
Autonomy	2.33	(.83)	.69	-
Communication Attempt	3.24	(.93)	.57	-
Self-Care	2.61	.80	-	-
Anti-Suicide	2.88	.84	-	-

Note: *M* – Mean; *SD* – Standard Deviation. Coefficients lower than .40 are suppressed.

Exploratory Factor Analysis for the Intrapersonal Functions.

EFA for the Intrapersonal factors showed an 8-factor solution (KMO = .91, χ^2 = 6213.38, $p < .001$), where the items 1 and 56 of the *Affect Regulation*; 3, 16, 28, 39, and 51 of the *Self-Punishment*; 48, 58, and 65 of the *Introspective Mechanism*; and 61 of *Escape Mechanism* were removed for loading lower than .40. A new EFA provided a 6-factor solution explaining 65.66% of the variance (KMO = .87, χ^2 = 3723.05, $p < .001$), where all *Replacement of Suffering* items loaded on factor 1; *Anti-Dissociation* items loaded on factor 2; *Escape Mechanism* items loaded on factor 3; *Affect Regulation* items loaded on factor 4; *Introspective Mechanism* items loaded on factor 5; and *Self-Punishment* items loaded on factor 6 (Table 3).

Table 3. Exploratory factor analysis for the intrapersonal functions

Items	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6
Item 44	.688					
Item 57	.742					
Item 64	.898					
Item 68	.781					
Item 74	.933					
Item 5		.548				
Item 18		.664				
Item 30		.618				
Item 50		.525				
Item 59		.586				
Item 40			.779			
Item 46			.570			
Item 67			.488			
Item 73			.659			
Item 14				.716		
Item 26				.578		
Item 49				.544		
Item 43					.535	
Item 72					.825	
Item 63						.896
Item 69						.433

Note. Exploratory factor analysis (Principal Axis with Promax rotation). Coefficients > .40. Factor 1 – Replacement of Suffering; Factor 2 – Anti-Dissociation; Factor 3 – Escape Mechanism; Factor 4 – Affect Regulation; Factor 5 – Introspective Mechanism; Factor 6 – Self-Punishment.

Exploratory Factor Analysis for the Interpersonal Functions.

The EFA for the Interpersonal factors (KMO = .894, $\chi^2 = 6058.97$, $p < .001$) provided an 8-factor solution in which all items from the *Marking Distress* function (i.e., 11, 24 and 36); 15, 45, and 60 of *Interpersonal Boundaries*; 7 from the *Sensation Seeking*; 9, 34, 41, and 53 from *Interpersonal Influence*; 42 and 66 from *Communication Attempt*; 12 and 55 from *Revenge*; and 13 from *Autonomy* were removed because of low coefficients. Items 54, 70, and 75 of the *Communication Attempt* factor were also removed for loading exclusively on the *Interpersonal Influence* factor. Additionally, both remaining items of the *Sensation Seeking* factor were removed for loading on different factors (i.e., item 20 loaded on the *Peer Bonding* factor and item 32 loaded on the *Toughness* and *Autonomy* factor).

After the item reduction process, an EFA provided a 4-factor solution with eigenvalues higher than 1 (57.07% of variance explained), where the *Peer Bonding* items loaded lower than .40 in every factor. A new EFA forcing to extract 5 factors provided the satisfactory solution presented in Table 4, explaining 64.00% of the variance (KMO = .789, $\chi^2 = 1374.441$, $p < .001$), where all items of both *Autonomy* and *Toughness* loaded exclusively on factor 1; items of *Interpersonal Influence* loaded on factor 2; *Interpersonal Boundaries* items loaded on factor 3; *Revenge* items loaded on factor 4; and *Peer Bonding* items loaded on factor 5.

Table 4. Exploratory factor analysis for the interpersonal functions

Items	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
Item 10	.513				
Item 23	.729				
Item 35	.725				
Item 25	.491				
Item 38	.412				
Item 22		.493			
Item 62		.785			
Item 71		.695			
Item 2			.549		
Item 27			.862		
Item 37				.671	
Item 47				.661	
Item 21					.759
Item 52					.682

Note: Exploratory factor analysis (Principal Axis with Promax rotation). Coefficients > .40. Factor 1 – Toughness and Autonomy; Factor 2 – Interpersonal Influence; Factor 3 – Interpersonal Boundaries; Toughness; Factor 4 – Revenge; Factor 5 – Peer Bonding.

Internal Consistency.

An analysis of the internal consistency of the questionnaire showed that both meta-factors of Intrapersonal (α = .89) and Interpersonal (α = .79) functions showed acceptable Cronbach's alphas. Furthermore, the functions showed generally acceptable scores of internal consistency (i.e., α ≥ .70), except for *Self-Punishment* (α = .65), *Introspective Mechanism* (α = .65), *Interpersonal Boundaries* (α = .63), *Peer Bonding* (α = .67), and *Revenge* (α = .65) that presented lower scores of Cronbach's Alphas, yet still acceptable for this early stage of this instrument (Field, 2013).

Study 2: Confirmatory Factor Analysis

Method

Participants.

The participants of Study 2 were students from the 7th to the 12th grade who frequented two public schools from the district of Leiria. 411 students filled out the questionnaire. Six foreigner participants were removed, so our final sample was comprised of 405 Portuguese nationals.

From this total, 214 (52.8%) participants were female and 191 (47.2%) were male. Their ages ranged from 12 to 19 years old, with a mean of 14.9 years (*SD* = 1.9). Participants frequented the 7th grade (23.2%), 8th grade (18.5%), 9th grade (8.6%), 10th (16.5%), 11th grade (18.8%) and 12th grade (14.3%). Regarding their family, 54.8% participants lived with their parents and siblings, 21.2% lived with their mother, 18.5% lived with their parents, 2.7% lived with their father, and 2.7% lived with other people.

Measures.

The instruments used the present study comprised the second version of the QRFDSH and a brief socio-demographic questionnaire. This version of the QRFDSH was reduced according to Study 1 and now comprised 11 functions and 35 items. This instrument included a short introduction mentioning that some people have deliberate self-harm, followed by examples of these behaviours. The sentence “When young people have these behaviours they are...” preceded the items. The answers were organized on a five point Likert scale: totally disagree, disagree, neither, agree, or totally agree.

The socio-demographic questionnaire included questions about the participants' gender, age, school grade and household.

Procedures.

We contacted several schools asking their permission to perform the study. After receiving the schools' administration authorisation, the classes were randomly selected and the dates for data collection were defined by the director of each class. Firstly, the researcher delivered the parent-consent forms to the students and in a second moment, the students

whose parents/legal guardians signed the consent form completed the questionnaire. The researcher informed the participants that their collaboration was voluntary and that the collected data was anonymous and confidential.

Data Analysis.

We carried out a reliability analysis of the QRFDSH through the calculation of Cronbach's alpha. We considered Cronbach's alphas equal or greater than .70 as indicative of satisfactory internal consistency (Field, 2013).

Furthermore, we conducted a Confirmatory Factor Analysis (CFA). Although our data did not fulfill the multivariate normality assumption (Ku_{Mult} = 399.17), skewness (min. = -1.19; max. = .57) and kurtosis (min. = -.86; max. = 1.43) absolute scores fell within Kline's (2005) criteria and demonstrated that the normality assumption was not grossly violated. Therefore, the CFA was conducted with the Maximum Likelihood method and we considered fit scores of Relative Chi-Square ($\chi 2/df$) lower than 5, Comparative Fit Index and Goodness-of-Fit Index (CFI and GFI) higher than .80; Parsimony Comparative Fit Index and Parsimony Goodness-of-Fit Index (PCFI and PGFI) higher than .60; and Root Mean Square Error of Approximation (RMSEA) lower than .10 as indicative of acceptable model fit (Maroco, 2010; Arbuckle, 2013).

Results

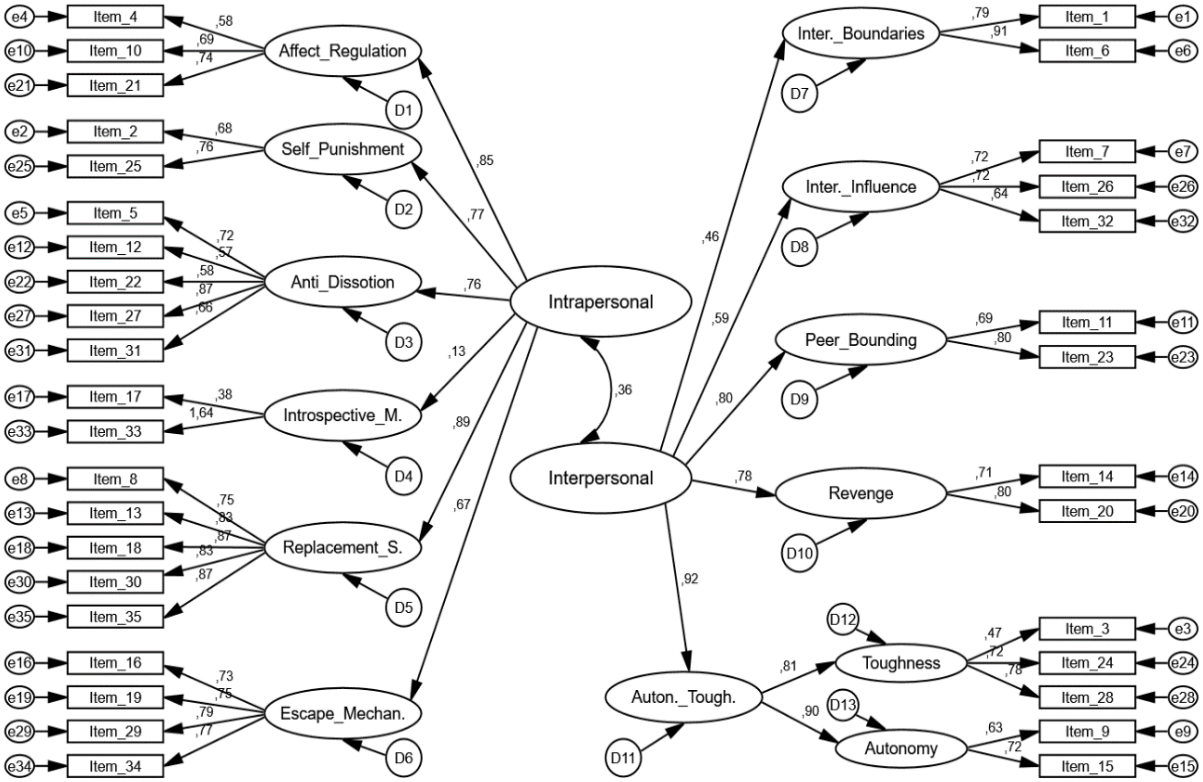
Reliability analysis for Study 2 showed good internal consistency for the Intrapersonal (α = .91) and satisfactory internal consistency for the Interpersonal (α = .84) meta-functions. In a more detailed analysis, we realize that all the functions presented acceptable to good internal consistency (ranging from α = .71 to α = .92), with exception of the *Self-Punishment* (α = .68) function, which presented slightly lower Cronbach's Alpha value (Table 5). The Confirmatory Factor Analysis for the factorial model developed in Study 1 and illustrated in Figure 1 showed an acceptable model fit ($\chi 2/df$ = 2.947, CFI = .84, PCFI = .77, GFI = .81, PGFI = .70, RMSEA = .069) (Figure 1).

Table 5. Internal Consistency for both studies

	Study 1			Study 2		
	M	*SD*	α	*M*	*SD*	α
Intrapersonal	3.33	.660	.89	3.36	.634	.91
Affect Regulation	3.79	.892	.70	3.73	.807	.71
Self-Punishment	3.42	.995	.65	3.58	.845	.68
Anti-Dissociation	2.95	.878	.75	2.95	.826	.81
Introspective Medium	2.67	1.044	.65	2.59	.960	.77
Replacement of Suffering	3.57	1.021	.90	3.67	.938	.92
Escape Mechanism	3.45	.906	.76	3.49	.896	.85
Interpersonal	2.57	.604	.79	2.66	.601	.84
Interpersonal Boundaries	2.68	.988	.63	3.08	.989	.84
Peer Bonding	2.06	.930	.67	2.38	.919	.71
Interpersonal Influence	2.98	.984	.71	2.92	.909	.73
Toughness & Autonomy	2.55	.801	.72	2.58	.725	.75
Revenge	2.38	1.009	.65	2.33	.890	.72

Note. *M* – Mean; *SD* – Standard Deviation; α – Cronbach's Alpha.

Figure 1. Confirmatory factor analysis of the model



Discussion

The purpose of these studies was to develop and validate the QRFDSH, an instrument dedicated to the assessment of adolescents' representations about the functions of deliberate self-harm. We utilized the ISAS (Klonsky & Glenn, 2008) as a basis since it was previously used in the study of these representations. After the translation and adaption of the ISAS to Portuguese, we performed two additional processes to complement the items and functions of this instrument. This resulted in a first version of the QRFDSH that comprised 79 items and evaluated 17 functions of deliberate self-harm (13 functions from the ISAS original structure and four functions that emerged from the interviews and written press analyses).

In Study 1, an EFA testing the two-functions model resulted in the elimination of *Self-Care* and *Anti-Suicide* functions. The remaining functions loaded on the correspondent factors described by Klonsky and Glenn (2008), except for *Marking Distress* which loaded on the interpersonal dimension. This fact can be theoretically explained because this function can be viewed as implying some sort of communication with others. However, this function was later removed from the scale due to unsatisfactory results in the following analyses.

Two additional EFAs were subsequently conducted to test all items of intrapersonal and interpersonal dimensions. The first EFA tested all items of the intrapersonal dimension, providing an unsatisfactory 8-factor solution. After the deleting of items with lower loadings, this EFA was repeated, and the new EFA revealed a satisfactory structure for six functions (*Affect Regulation*, *Anti-Dissociation*, *Escape Mechanism, Introspective Mechanism, Replacement of Suffering* and *Self-Punishment*). The second EFA tested the items of the interpersonal dimension and also provided an unacceptable 8-factor solution. Once again, after the item reduction process, the EFA was repeated, resulting in a structure of four factors. A new EFA constrained to extract five factors provided a satisfactory solution that included five functions (*Autonomy* and *Toughness*, *Interpersonal Influence*, *Interpersonal Boundaries*, *Revenge*, and *Peer Bonding*).

In this 5-factor structure items from both *Autonomy* and *Toughness* aggregated on the same factor. Since *Autonomy* is based on the idea that the self-harmer does not need help from others, and *Toughness* refers to the ability of the self-harmer to deal with pain on his own, we consider that these functions share a fundamental notion of self-reliance and individuality. For this reason, the loading of these two functions on the same factor is not incompatible nor theoretically incongruent.

The aforementioned EFAs also allowed us to reduce the scale. From the initial 79 items, 35 remained, of which 20 were new items that derived from the results of the semi-directive interviews and written press analyses. Regarding the functions of deliberate self-harm, from the initial 17 functions, 11 remained in the final version of the scale. Focusing on the functions that were added to the scale, only three of four new functions remained, namely *Escape Mechanism*, *Introspective Mechanism* and *Replacement of Suffering*. The factor analyses revealed that these three functions aggregate in the intrapersonal dimension, which is consistent with their nature. Furthermore, the analyses of the internal consistency of these functions demonstrate good properties in both studies.

The five functions that were eliminated during this process comprised *Anti-Suicide*, *Communication Attempt*, *Marking Distress*, *Self-Care*, and *Sensation Seeking*. Their elimination may imply that our sample of Portuguese adolescents did not have clear representations about these functions of deliberate self-harm.

Study 2 was a CFA designed to test the factorial structure of the instrument, including its two dimensions (interpersonal and intrapersonal) and 11 functions. Our results reveal a good model with a stable two-factor structure, which is in accordance with previous research that utilized the ISAS (Bildik et al., 2013; Klonsky et al., 2015; Kortge et al., 2013). The factorial organization of the five interpersonal functions and the six intrapersonal functions also presented good reliability. Nonetheless, we did not find any studies that evaluated the factorial validity of these functions independently.

Overall, the QRFDSH for adolescents revealed good psychometric properties, specifically regarding its reliability and its factorial validity. Our results demonstrated a robust two-factor structure of the interpersonal/intrapersonal dimensions and an acceptable factorial structure concerning the 11 functions' scales. Hence, we believe that this questionnaire will be useful both to research and clinical settings, and also contributing for the understanding of the representations about the functions of deliberate self-harm.

Limitations and Directions for Future Research

Our research has limitations that should be recognized. One limitation is based on the samples used in both studies since they are relatively homogenous. Also, the QRFDSH was not tested regarding its divergent and convergent validity with other variables. These limitations could be overcome with further studies.

Clearly, additional research is needed in this area. Although deliberate self harm behaviours are increasing in adolescence (e.g. Hawton et al., 2012) and this phenomenon is gaining more visibility in the media (e.g. Whitlock et al., 2009), there is still a general lack of information regarding the representations of individuals that did not have direct contact with these behaviours. In addition, there is the need to create instruments to assess the representations about these behaviours and contribute to their understanding. Regarding previous research, most investigations followed a qualitative approach that limits the findings' scope. Hence, future studies could focus on the study of the representations about deliberate self-harm using quantitative methodology. We hope that the QRFDSH can be important for subsequent investigations focused on the study of Portuguese adolescents' representations about the functions of deliberate self-harm (in samples with and without these behaviours).

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Representations about the Functions of Deliberate Self-Harm: Construction and Validation of a Questionnaire for Portuguese Adults*

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Abstract

The present article focuses on the validation of the Questionnaire of Representations about the Functions of Deliberate Self-Harm for adults. The understanding of the representations about deliberate self-harm can be relevant for clinical intervention and prevention. However, there is still a lack of instruments to assess these representations.

The basis for this instrument was the translation of the Inventory of Statements About Self-Injury. To complement this instrument, we conducted semi-directive interviews with adults without deliberate self-harm and analysed the Portuguese written press. Results from these studies complemented the questionnaire with new items and functions.

Study 1 consisted of an exploratory factor analysis with a sample of 462 adults. Results revealed a two-factor structure of interpersonal and intrapersonal dimensions. After item reduction, the factorial analysis of the independent functions was also acceptable. This structure was then corroborated in Study 2 by a confirmatory factor analysis with a new sample of 474 adults, revealing an acceptable model fit.

This questionnaire presents a relatively solid structure and is based on acceptable psychometric properties, which allows its use in future research.

Keywords: Deliberate Self-Harm; Adults; Questionnaire; Validation; Factor Analysis

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* Paper submitted to the journal *Behaviour Change*

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Introduction

Deliberate self-harm consists in a range of self-aggressive behaviours with or without suicidal intent (Guerreiro, Sampaio, Figueira & Madge, 2017; Hawton, Saunders & O'Connor, 2012; Madge et al., 2008). In the past decades, deliberate self-harm has become more prevalent among adolescents (e.g. Hawton et al., 2012). In Portugal, the prevalence rates range from 7.3% to 28% (Gonçalves, Martins, Rosendo, Machado & Silva, 2012; Guerreiro et al., 2017; Gouveia-Pereira, Gomes, Santos, Frazão & Sampaio, 2016), which is identical to other international studies (Brunner et al., 2013; Muehlenkamp, Claes, Havertap & Plener, 2012).

Due to the increased awareness about deliberate self-harm among adolescents, research about this phenomenon has also increased (Jacobson & Gould, 2007; Meszaros, Horvath & Balazs, 2017). Additionally, studies have found that there is a crescent visibility of these behaviours in the general media and internet (Niwa & Mandrusiak, 2012; Reddy, Rokito & Whitlock, 2016; Swannell et al., 2010; Trewavas, Hasking & McAllister, 2010; Whitlock, Powers & Eckenrode, 2006; Whitlock, Purington & Gershkovich, 2009; Zdanow & Wright, 2012). However, though media representations about self-harm are increasingly available, it is unclear how these representations influence the behaviours of viewers and participants (Whitlock et al., 2009). For instance, as Reddy et al. (2016) stated, it may help those who engage in these behaviours feel less isolated, but it may also increase interest in trying or adopting self-harm as a way of coping with stress or distress.

This crescent visibility in the media can confront the general public with the existence of deliberate self-harm and, subsequently, to build and modify its representations. Therefore, understanding how this phenomenon is viewed by others may have important implications for clinical intervention and prevention programs (Bresin, Sand & Gordon, 2013). Moreover, representations specifically about the functions of deliberate self-harm can be quite relevant in terms of intervention and social support. For instance, if friends and family members have an inaccurate understanding of these functions (e.g., believing the behavior to be an act of manipulation instead of support-seeking), it may lead to responses towards the individual that inadvertently exacerbate the frequency and severity of the behaviours (Bresin et al., 2013).

Several studies have explored and described adults' perceptions and attitudes towards deliberate self-harm. Most of the existing literature has focused on the perspectives of parents of adolescents who self-harm (Ferrey et al., 2016; McDonald, O'Brien & Jackson, 2007; Oldershaw, Richards, Simic & Schmidt, 2008; Rissanen, Kylmä & Laukkanen, 2009),

healthcare professionals (Karman, Kool, Poslawsky & Van Meijel, 2015; Lindgren, Oster, Aström & Graneheim, 2011; McHale & Felton, 2010; Rees, Rapport, Thomas, John & Snooks, 2014), counsellors (De Stefano, Atkins, Noble & Heath, 2012; Fox, 2011; Long & Jenkins, 2010), and teachers (Berger, Hasking, Reupert, 2014; Heath, Toste & Beettam, 2007; Heath, Toste, Sornberger & Wagner, 2011).

Nonetheless, there are various limitations to the current knowledge about the representations of deliberate self-harm. First of all, most of the studies are based on samples that had some type of direct contact with deliberate self-harm (e.g. parents of adolescents with these behaviours or healthcare professionals who dealt with patients who self-harmed). Secondly, most research utilized qualitative designs, which allows more comprehensive results but also limits their scope and generalization. In addition, a great part of this research centered exclusively on the attitudes about deliberate self-harm, not exploring the representations about its functions.

Taking these factors into account, it is important to build a questionnaire to assess the representations about the functions of deliberate self-harm. Hence, our main goal was to develop an instrument aimed at adults with and without direct contact with these behaviours.

Although there are several instruments that focus on the study of deliberate self-harm, we did not find any instrument exclusively dedicated to the representations about the functions of these behaviours. The exception is a study developed by Batejan, Swenson, Jarvi and Muehlenkamp (2015), which compared the views of deliberate self-harm between college students with and without a history of these behaviours. In this study, the authors used the Inventory of Statements About Self-Injury (ISAS), despite the fact it is not an instrument aimed at the study of the representations of this phenomenon. This inventory was developed by Klonsky & Glenn (2008) and comprises two components. The first section lists several methods of deliberate self-harm. The second section should only be completed by respondents who have a history of self-harm and evaluates 13 types of functions of these behaviours. The functions presented in this instrument are organized in a two-factor structure (intrapersonal and interpersonal functions).

Due to the previous employment of the ISAS in this research area (Batejan et al., 2015) and taking into consideration the variety of functions it evaluates, we opted on utilizing the second component of this instrument as a basis for the development of our questionnaire. However, since the ISAS was originally aimed at adolescents who have a history of deliberate self-harm, there was the need to complement its contents according to the representations of

non self-harmers and adults. For this purpose, two additional studies were conducted (detailed in the questionnaire development section), whose results allowed us to add more items and functions to the questionnaire.

The current article presents two studies that analysed psychometrically our questionnaire (Questionnaire of Representations About the Functions of Deliberate Self-Harm, QRFDSH) in a sample of Portuguese adults. We intended to test its factorial structure regarding the two dimensions (interpersonal and intrapersonal) and the various independent functions. In Study 1 we conducted an exploratory factor analysis of the functions of deliberate self-harm and the interpersonal and intrapersonal dimensions, which also allowed us to reduce the QRFDSH through a process of item elimination. This reduced version of the instrument and its factorial structure were evaluated in Study 2, with an independent sample. The internal consistency of the questionnaire was also tested.

Questionnaire Development

The QRFDSH comprises items from three different sources: the translation of the ISAS (Klonsky & Glenn, 2008), items that emerged from the analysis of semi-directive interviews and items that resulted from the analysis of Portuguese written press.

Translation and Adaptation of the Inventory of Statements About Self-Injury

The translation and adaptation of the ISAS was the first step in the construction of our questionnaire. The first section of the ISAS has already been validated to Portuguese adolescents (Duarte, Gouveia-Pereira & Sampaio, in press).

As previously stated, we translated and adapted the second part of the ISAS, which consists of statements about the functions of deliberate self-harm. It is composed of 39 items that correspond to 13 functions of deliberate self-harm, which are subsequently organized in two dimensions. The interpersonal dimension consists of eight subscales: *Autonomy*, *Interpersonal Boundaries*, *Interpersonal Influence*, *Peer Bonding*, *Revenge*, *Self-Care*, *Sensation Seeking*, and *Toughness*. The intrapersonal dimension includes five subscales: *Affect Regulation*, *Anti-Dissociation*, *Anti-Suicide*, *Marking Distress*, and *Self-Punishment*.

The second section of the ISAS has demonstrated good psychometric properties. It has revealed good total internal consistency, with total values of Cronbach's Alpha of .93 (Bildik, Somer, Kabukçu-Başay, Başay & Özbaran, 2013) and Cronbach's Alpha for the interpersonal

and intrapersonal scales of .88 and .80, respectively (Klonsky & Glenn, 2008). Likewise, it has shown good test-retest reliability, with correlations of .60 for the intrapersonal functions, . 82 for the interpersonal functions, and values ranging from .35 to .89 regarding individual functions (Glenn & Klonsky, 2011). The theorised two-factor structure (i.e. interpersonal and intrapersonal dimensions) has also been confirmed by the literature (Klonsky, Glenn, Styer, Olino & Washburn, 2015; Kortge, Meade & Tennant, 2013).

The translation process of the ISAS followed the adequate procedures. We contacted six psychologists fluent in English and with knowledge about deliberate self-harm. Three of them translated the original items to Portuguese. Subsequently, three different psychologists retro-translated these items into English. The final versions resulting from this process were compared with the original instrument and the most similar items were selected.

Analysis of Semi-Directive Interviews

The present study consisted of a qualitative analysis of the representations about the functions of deliberate self-harm from adults. The sample comprised 15 adults without these behaviours, who were recruited through personal contacts that snowballed into other connections.

According to information present in the literature, the interview script was designed to assess the representations about the functions of deliberate self-harm. Through content analysis, all the statements were coded and sorted into categories based on how different codes/statements were related and linked (Hsieh & Shannon, 2005). Afterwards, the categories with more than two codes were selected and the respective statements were converted into items. Four new functions emerged from these results (*Communication Attempt, Escape Mechanism, Introspective Mechanism, and Replacement of Suffering*), as well as new items that complement existing functions (Table 3).

Analysis of the Portuguese Written Press

In this study, we focused on the analysis of news published during 11 years (between January 2004 and December 2015) in seven different Portuguese generalist publications (five newspapers and two magazines). Using 18 search terms associated with deliberate self-harm, 639 news were collected. These news were analyzed following content analysis procedures and the text was divided into the categories defined according to the functions present in the

ISAS. This process allowed the formulation new items that complemented several functions from the ISAS.

Final Structure of the QRFDSH

From the analyses of the semi-directive interviews and written press, 36 new items emerged. From this total, 16 items complemented some of the functions presented in the ISAS and 20 corresponded to four new functions (Table 1). Hence, this first version of the QRFDSH is composed of 17 functions of deliberate self-harm and 75 items.

Table 1. Structure of the QRFDSH with the new functions and new items

Dimension	Function	Number of Original Items	Number of New Items
Interpersonal	Autonomy	3	0
	Communication Attempt *	0	5
	Interpersonal Boundaries	3	2
	Interpersonal Influence	3	4
	Peer Bonding	3	1
	Revenge	2	2
	Self-Care	3	0
	Sensation Seeking	3	0
	Toughness	3	0
Intrapersonal	Affect Regulation	3	2
	Anti-Dissociation	3	2
	Anti-Suicide	3	0
	Escape Mechanism *	0	5
	Introspective Mechanism *	0	5
	Marking Distress	3	0
	Replacement of Suffering *	0	5
	Self-Punishment	4	3

Note: * - New functions.

Study 1: Exploratory Factor Analysis

Method

Participants.

The sample was collected on the internet through the advertising of the questionnaire on social media websites and online forums. During two months, 473 participants completed the questionnaire, of which 11 were foreigners. Therefore, the sample for this study was comprised of 462 subjects with Portuguese nationality.

From this total, 246 (53.2%) participants were female, 213 (46.1%) were male, and three (0.6%) identified with other gender. Their ages ranged from 20 to 69 years old, with a mean of 36.9 years (SD=11.4). Regarding education level, most participants had a college/university degree (67.1%), while 27.7% studied from the 10th to 12th grade and 5.2% studied from the 5^{h} to 9th grade. The participants were single (52%), married (21.3%), in a domestic partnership (16.1%), divorced (7%), widowed (2.4%) or other. 32.5% of the participants had children.

Measures.

In the current study, we utilized the first version of the QRFDSH and a brief socio-demographic questionnaire. The QRFDSH began with a short introduction mentioning that some adolescents may have deliberate self-harm, followed by examples of these behaviours. Since this questionnaire will mainly be answered by non self-harmers, the initial sentence of the ISAS ("When I self-harm, I am...") was changed to "When young people have these behaviours they are...". Furthermore, in order to allow more detailed data we reorganized the answers on a five-point Likert scale which refers to the degree of accordance with each item: totally disagree, disagree, neither, agree, or totally agree.

The socio-demographic questionnaire included questions about the participants' age, gender, nationality, education level, marital status and existence of children.

Procedures.

After the translation and adaptation of the ISAS, the new items that emerged from the analyses of semi-directive interviews and of the Portuguese written press were added to the

instrument. Before data collection, a group of adults completed the questionnaire and shared their possible doubts about the items, in order to confirm the instrument was easily comprehended.

As previously mentioned, the data was collected on the internet through a website dedicated to the building and display of surveys. The link to this website was advertised on social media websites and online forums. The quantitative data provided by the survey website was later transposed into a database and reviewed for errors.

Data Analysis.

All statistical analyses were carried out using SPSS v22 software and Amos Version 22.0 (IBM SPSS, Chicago, IL).

The Exploratory Factor Analysis (EFA) was carried out in two different steps. First, we developed an EFA testing the two-factor structure of interpersonal and intrapersonal functions. Second, we carried out separately EFAs for items in the interpersonal and intrapersonal functions, from which derived an item reduction process (i.e., items with factor loadings lower than .40 were excluded). All EFAs were developed with Principal Axis Factoring extraction method and Promax with Kaiser Normalization rotation.

Furthermore, we developed a series of Confirmatory Factor Analyses (CFA) with the Maximum Likelihood method and carried out a second item reduction process considering the Modification Indices based on the Lagrange Multiplier. Although the items did not fulfill the multivariate normality assumption (ku_{Mult} = 567.43), we considered Kline's (2005) criteria (i.e., SK-skewness lower than 3 and K-kurtosis lower than 8) to demonstrate that our results did not grossly violate the normality assumption (SK ranging from -1.312 to .733; K ranging from -1.06 to 3.465). We considered the following fit indexes: Relative Chi-Square (χ^2/df lower than 5); Comparative Fit Index and Goodness-of-Fit Index (CFI and GFI higher than . 80); Parsimony Comparative Fit Index and Parsimony Goodness-of-Fit Index (PCFI and PGFI higher than .60); and Root Mean Square Error of Approximation (RMSEA lower than . 10) (Maroco, 2010; Arbuckle, 2013).

Results

A first EFA testing the two-functions model provided a four-factor solution with eigenvalues higher than 1. Therefore, a second EFA fixed to extract a two-factor solution was

developed, which explained 50.86% of the variance (KMO = .85, $\chi^2 = 4057.91$, $p < .001$). As illustrated in Table 2, the functions of *Interpersonal Boundaries*, *Sensation Seeking*, *Peer Bonding*, *Interpersonal Influence*, *Toughness*, *Revenge*, *Autonomy*, and *Communication Attempt* all loaded exclusively on factor 1 (i.e., interpersonal functions); whereas *Affect Regulation*, *Self-Punishment*, *Anti-Dissociation*, *Anti-Suicide*, *Marking Distress*, *Self-Care*, *Introspective Mechanism*, *Replacement of Suffering*, and *Escape Mechanism* all loaded exclusively on factor 2 (i.e., intrapersonal functions).

Table 2. Exploratory factor analysis for the two-factor model

Functions	*M*	*(SD)*	*Factor 1 - Interpersonal*	*Factor 2 - Intrapersonal*
Affect Regulation	3.67	(.68)		.853
Self-Punishment	3.54	(.65)		.520
Anti-Dissociation	3.45	(.72)		.608
Anti-Suicide	2.98	(.82)		.436
Marking Distress	3.46	(.76)		.546
Introspective Mechanism	3.03	(.70)		.521
Replacement of Suffering	3.95	(.76)		.839
Self-Care	3.03	(.79)		.428
Escape Mechanism	3.53	(.64)		.459
Interpersonal Boundaries	2.55	(.72)	.804	
Sensation Seeking	2.57	(.81)	.724	
Peer Bonding	2.31	(.77)	.763	
Interpersonal Influence	3.31	(.85)	.663	
Toughness	2.74	(.89)	.596	
Revenge	2.73	(.87)	.779	
Autonomy	2.41	(.77)	.616	
Communication Attempt	3.62	(.81)	.436	

Note: *M* – Mean; *SD* – Standard Deviation. Coefficients lower than .40 are suppressed.

Exploratory Factor Analysis for the Intrapersonal Functions.

The EFA for all items of intrapersonal factors provided a 9-factor solution (KMO = . 91, $\chi^2 = 9019.70$, $p < .001$), though some items showed coefficients lower than .40. Therefore, items 49 and 56 of the *Affect Regulation*; 28 of the *Self-Punishment*; 17 of the *Self-Care*; 40 and 61 of *Escape Mechanism*; and item 11 of the *Marking Distress* were removed. After concluding the item reduction process, the EFA provided a satisfactory 9-factor solution, explaining 66.78% of the variance (KMO = .89, $\chi^2 = 7292.58$, $p < .001$), presented in Table 3.

Table 3. Exploratory factor analysis for the intrapersonal functions

Items	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7	Factor 8	Factor 9
Item 44	.724								
Item 57	.804								
Item 64	.875								
Item 68	.817								
Item 74	.907								
Item 3		.611							
Item 16		.435							
Item 39		.581							
Item 51		.851							
Item 63		.603							
Item 69		.896							
Item 43			.609						
Item 48			.520						
Item 58			.532						
Item 65			.649						
Item 72			.767						
Item 5				.599					
Item 18				.648					
Item 30				.565					
Item 50				.592					
Item 59				.593					
Item 6					.850				
Item 19					.685				
Item 31					.714				
Item 46						.818			
Item 67						.527			
Item 73						.652			
Item 1							.611		
Item 14							.471		
Item 26							.527		
Item 4								.746	
Item 29								.652	
Item 24									.630
Item 36									.747

Note: Exploratory factor analysis (Principal Axis with Promax rotation). Coefficients > .40. Factor 1 - Replacement of Suffering; Factor 2 - Self-Punishment; Factor 3 - Introspective Mechanism; Factor 4 - Anti-Dissociation; Factor 5 - Anti-Suicide; Factor 6 - Escape Mechanism; 7 - Affect Regulation; Factor 8 - Self-Care; Factor 9 - Marking Distress.

Exploratory Factor Analysis for the Interpersonal Functions.

Regarding the interpersonal factors, a similar process (KMO = .936, $\chi^2 = 9327.867$, $p < .001$) resulted in the elimination of the following items: items 15, 45, and 60 of *Interpersonal Boundaries*; items 7 and 32 of *Sensation Seeking*; and item 34 from *Interpersonal Influence*. Moreover, the *Sensation Seeking* factor was removed because the unique reminding item (i.e., item 20) loaded on the *Peer Bonding* factor; in the same manner, the *Communication Attempt* factor was removed because all items (i.e., items 42, 54, 66, 70, and 75) loaded on the *Interpersonal Boundaries* factor. A final EFA provided a 5-factor solution where items from both *Autonomy* and *Toughness* loaded on the same factor (which did not disentangle even when the EFA was fixed to 6 factors). Therefore, we considered the 5-factor model a satisfactory factor solution, explaining 65.40% of the variance (KMO = .912, $\chi^2 = 4914.210$, $p < .001$), presented in Table 4.

Table 4. Exploratory factor analysis for the interpersonal functions

Items	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
Item 9	.636				
Item 22	.672				
Item 41	.572				
Item 53	.725				
Item 62	.835				
Item 71	.898				
Item 10		.644			
Item 23		.840			
Item 35		.641			
Item 13		.497			
Item 25		.708			
Item 38		.540			
Item 12			.704		
Item 37			.736		
Item 47			.721		
Item 55			.775		
Item 8				.808	
Item 21				.792	
Item 33				.564	
Item 52				.759	
Item 2					.661
Item 27					.743

Note: Exploratory factor analysis (Principal Axis with Promax rotation). Coefficients > .40. Factor 1 - Interpersonal Influence; Factor 2 – Autonomy and Toughness; Factor 3 - Revenge; Factor 4 - Peer Bonding; Factor 5 - Interpersonal Boundaries.

Confirmatory Factor Analysis.

The CFA revealed an unsatisfactory solution (χ^2/df = 2.684, CFI = .81, PCFI = .77, GFI = .75, PGFI = .69, RMSEA = .060), once the GFI index did not reach the minimum threshold of .80 (Maroco, 2010). Therefore, we considered the Modification Indices (MI), and the items 47 (MI = 60.01), 50 (MI = 34.24), 37 (MI = 33.05), 62 (MI = 24.44), 59 (MI = 22.88), 64 (MI = 22.72), and 43 (MI = 18.86) were removed. The final solution presented satisfactory fit indices (χ^2/df = 2.499, CFI = .84, PCFI = .79, GFI = .80, PGFI = .72, RMSEA = .057).

Internal Consistency.

Finally, as illustrated in Table 5, with exclusion of the *Interpersonal Boundaries* (α = . 68) that presented low but still acceptable Cronbach's Alphas (Field, 2013), all functions presented satisfactory to good internal consistency (from α = .70 to α = .90). Furthermore, all intrapersonal items showed good internal consistency (α = .90) and interpersonal functions just slightly lower (α = .89).

Study 2: Confirmatory Factor Analysis

Method

Participants.

The participants of this study were parents of adolescents who frequented two public schools in the district of Leiria. 484 parents completed the questionnaire. Ten foreigner participants were removed, so our final sample was comprised of 474 Portuguese nationals.

From this total, 262 (55.3%) participants were female and 212 (44.7%) were male. Their ages ranged from 33 to 62 years old, with a mean of 46.1 years (SD=5.51). In terms of education level, 34.5% of the participants had a college/university degree, 31.9% studied from 10th to 12th grade, 28.9% studied from the 5th to 9th grade and 4.8% studied until the 4th grade. Most participants were married (77.3%), while 10.2% were in a domestic partnership, 8.5% were divorced, 3.2% were single and 0.8% were widowed.

Measures.

The instruments used in this study comprised the second version of the QRFDSH and a brief socio-demographic questionnaire. This version of the QRFDSH was reduced according to Study 1 and now presented 14 functions and 49 items. This instrument included a short introduction mentioning that some people have deliberate self-harm, followed by examples of these behaviours. The sentence "When young people have these behaviours they are..." preceded the items. The answers were organized on a five-point Likert scale: totally disagree, disagree, neither, agree, or totally agree.

The socio-demographic questionnaire presented questions about the participants' age, gender, nationality, education level, marital status and existence of children.

Procedures.

The study was carried out with the approval of the administrative office at each school. Participants were recruited through the selection of several classes from different school years. The students received a notification to deliver to their parents or legal guardians, requesting their participation in the study. On a second moment, after parents' consent, the students delivered the questionnaire to their parents. The participants were informed about the purpose of the investigation and about the confidentiality and anonymity of the collected data.

Data Analysis.

Internal consistency was assessed through the Cronbach's Alpha and Confirmatory Factor Analysis (CFA) was carried out with the Maximum Likelihood method considering the Modification Indices based on the Lagrange Multiplier. Similar to Study 1, we considered the following fit indexes: Relative Chi-Square (χ^2/df lower than 5); Comparative Fit Index and Goodness-of-Fit Index (CFI and GFI higher than .80); Parsimony Comparative Fit Index and Parsimony Goodness-of-Fit Index (PCFI and PGFI higher than .60); and Root Mean Square Error of Approximation (RMSEA lower than .10) (Maroco, 2010; Arbuckle, 2013).

All statistical analyses were carried out using SPSS v22 software and Amos Version 22.0 (IBM SPSS, Chicago, IL).

Results

Internal Consistency .

Regarding the factors' internal consistency, data shows that the functions of *Marking Distress* (α = .63) and *Self-Care* (α = .68) presented low but still acceptable Cronbach's Alphas (Field, 2013). Additionally, all remaining functions presented satisfactory to good internal consistency (from α = .71 to α = .91). Furthermore, the meta-factor of intrapersonal functions showed very good internal consistency (α = .95) and interpersonal functions showed good internal consistency (α = .92).

Table 5. Internal consistency for both studies

	Study 1			Study 2		
	M	*SD*	α	*M*	*SD*	α
Intrapersonal	3.42	.47	.90	3.05	.63	.95
Affect Regulation	3.54	.79	.70	2.98	.84	.71
Self-Punishment	3.48	.70	.84	3.18	.76	.87
Anti-Dissociation	3.56	.81	.77	2.93	.86	.79
Anti-Suicide	2.98	.82	.80	2.69	.77	.78
Marking Distress	3.62	.81	.70	3.16	.84	.63
Introspective Mechanism	3.15	.73	.76	2.91	.76	.81
Replacement of Suffering	3.94	.76	.90	3.41	.87	.91
Self-Care	2.78	.88	.70	2.62	.84	.68
Escape Mechanism	3.40	.75	.71	3.23	.81	.76
Interpersonal	2.74	.61	.89	2.85	.64	.92
Interpersonal Boundaries	2.80	.88	.68	2.73	.91	.76
Peer Bonding	2.31	.77	.83	2.58	.79	.83
Interpersonal Influence	3.29	.91	.87	3.39	.78	.82
Autonomy & Toughness	2.57	.76	.84	2.63	.79	.89
Revenge	2.71	.94	.73	2.80	.92	.73

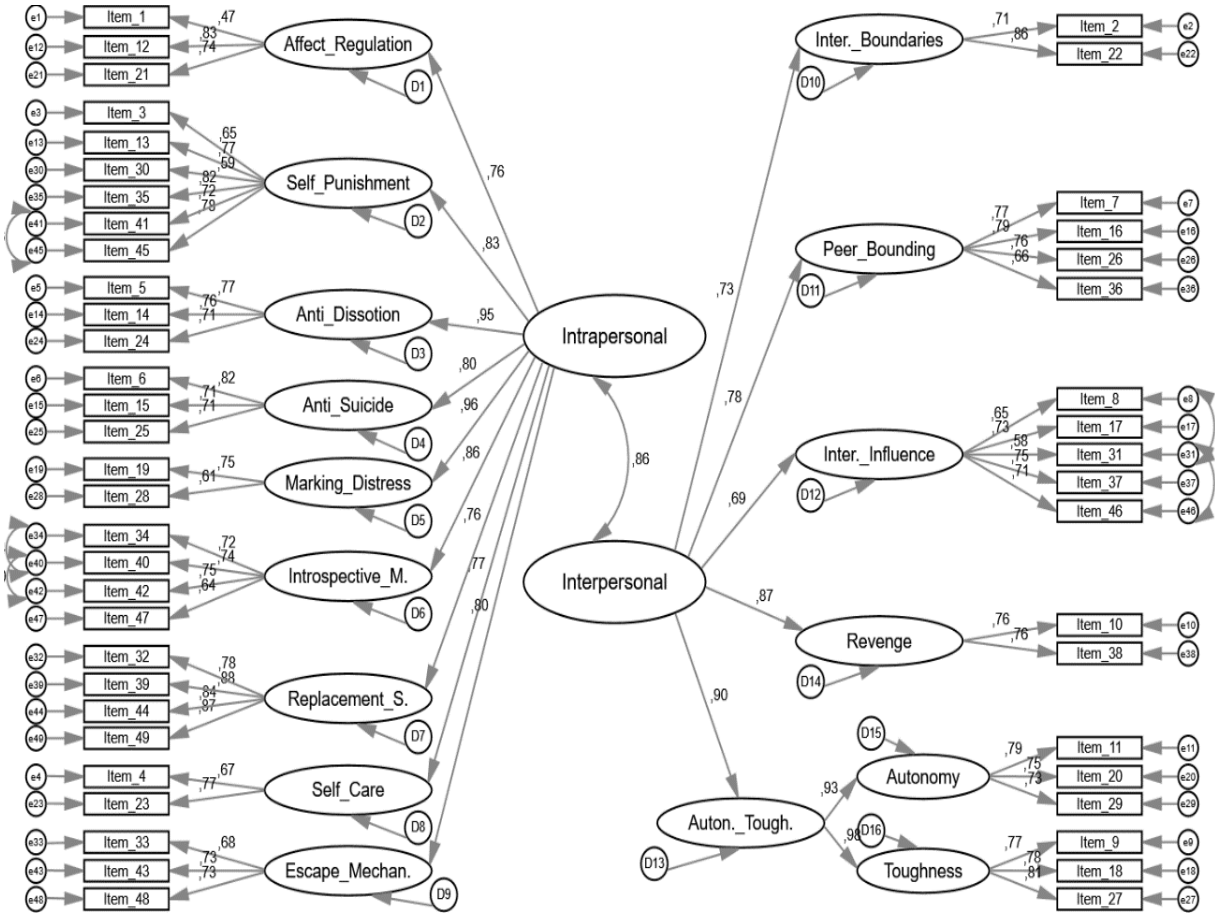
Note: *M*- Mean; *SD*- Standard Deviation; α- Cronbach's Alpha.

Confirmatory Factor Analysis.

Similar to study 1, items failed to present multivariate normality (kuMult = 875.19). Nevertheless, skewness (ranging from -.995 to .326) and kurtosis (ranging from -1.080 to .

916) absolute values fit under the Kline's (2005) criteria, showing that these results do not grossly violate the normality assumption. The CFA results, after considering the Modification Indices and covariate the errors of six pairs of items, showed a generally acceptable model fit ($\chi 2/df$ = 3.668, CFI = .80, PCFI = .75, GFI = .71, PGFI = .64, RMSEA = .075), with the exception of the Goodness-of-Fit Index that failed to reach the minimum threshold of .80 (Maroco, 2010) (Figure 1).

Figure 1. Confirmatory factor analysis of the model



Discussion

The objective of this research was to develop and evaluate the QRFDSH, an instrument designed to assess adults' representations about the functions of deliberate self-harm. To build this instrument we utilized the ISAS (Klonsky & Glenn, 2008) as a basis, since it was previously used in the study of these representations and briefly summarizes 13 functions of deliberate self-harm. Besides translating and adapting the ISAS to Portuguese, we conducted two additional studies to complement the items and functions of this instrument. The results from both studies allowed us to add more functions and items to the

ISAS original structure. Hence, the first version of the QRFDSH comprised 79 items that evaluated 17 functions of deliberate self-harm. Of this total, 13 functions were described in the ISAS and four functions derived from our additional studies.

In Study 1, a first EFA testing the two-functions model provided a four-factor solution. Therefore, a second EFA fixed to extract a two-factor solution was developed. All the functions loaded in the correspondent factors described by Klonsky and Glenn (2008), except for *Self-Care.* In our results, this function aligned as an intrapersonal function, which was theoretically expected but not found in the original study (Klonsky & Glenn, 2008) and was later reported in other studies (Kortge et al., 2013).

Following this step, we performed an additional EFA to test all items of intrapersonal factors, which provided a 9-factor solution, and another EFA to test all items of interpersonal factors, which provided a 5-factor solution. In this 5-factor structure, items from both *Autonomy* and *Toughness* loaded on the same factor. Although these two functions are distinct, we consider they share a fundamental notion of self-reliance and individuality since *Autonomy* is based on the idea that the self-injurer does not need help from others, and *Toughness* refers to the ability of the self-injurer to deal with pain on his own. Therefore, the loading of these two functions on the same factor is not incompatible nor theoretically incongruent.

These EFAs also allowed us to reduce the scale. Hence, from the initial 79 items, 45 remained, 19 of which were new items derived from the results of the semi-directive interviews and written press analysis. Of the 17 functions of deliberate self-harm, 14 also remained. Focusing specifically on the functions that were added to the scale according to the mentioned process, only three of four new functions remained. These included *Escape Mechanism*, *Introspective Mechanism* and *Replacement of Suffering*. The factor analyses demonstrated that these three functions aggregate in the intrapersonal dimension, which is consistent with their nature. Furthermore, the analyses of the internal consistency of these functions demonstrate good properties in both studies, as well as the reliability of the two dimensions. During this process, the functions *Communication Attempt* and *Sensation Seeking* were eliminated.

Study 2 consisted of a CFA designed to test the factorial structure of the scale, including the two dimensions (interpersonal and intrapersonal) and 14 functions. Our results demonstrate a good model with a stable two-factor structure, which is in supported by previous research that utilized the ISAS (Bildik et al., 2013; Klonsky et al., 2015; Kortge et

al., 2013). The factorial organization of the five interpersonal functions and the nine intrapersonal functions also presented good reliability. Nonetheless, we did not find any studies that evaluated the factorial validity of these functions independently.

Overall, the QRFDSH for adults revealed acceptable psychometric properties, namely regarding its reliability and its factorial validity. It exhibited a robust two-factor structure of the interpersonal/intrapersonal dimensions and an acceptable factorial structure concerning the 14 functions' scales. These results allow the further use of this scale in research and in clinical settings.

Limitations and Directions for Future Research

The present research has limitations that should be noted. One limitation concerns the samples used in both studies, due to the fact that they are relatively homogenous. Secondly, the QRFDSH was not tested regarding its divergent and convergent validity with other variables. Both limitations could be overcome with further studies.

Since deliberate self-harm is increasing in adolescence (e.g. Hawton et al., 2012) and this phenomenon is gaining more visibility in the media (e.g. Whitlock et al., 2009), further research is clearly needed in this area. There is still limited information regarding the representations of individuals that did not have direct contact with these behaviours and most existing investigations followed a qualitative approach. Hence, it is fundamental to build instruments to assess the representations about deliberate self-harm.

Future research could focus on the study of the representations about deliberate self-harm in different social groups, resorting to quantitative methodology so that it is possible to design comparative studies. Thus, we hope that the QRFDSH can be used in investigations focused on the study of Portuguese adults' representations about the functions of deliberate self-harm in samples with and without these behaviours.

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Social Representations about the Functions of Deliberate Self-Harm: Adolescents and Parents*

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Abstract

The understanding of the social representations about the functions of deliberate self-harm can be an important factor for the comprehension of this phenomenon. Nonetheless, there are few studies that focused on this topic and specifically on the social representations from adolescents with and without a history of deliberate self-harm and their parents.

This article presents two studies that aimed to analyze the social representations about the functions of deliberate self-harm from adolescents and parents. Study 1 compared the social representations from adolescents with and without these behaviours. Study 2 focused on the comparison of the social representations from parents (mothers and fathers) of adolescents with and without these behaviours.

Results revealed several differences between the groups. In summary, adolescents without deliberate self-harm perceived all the interpersonal functions as more relevant, while adolescents with deliberate self-harm emphasized some intrapersonal functions. Regarding parents, results revealed some differences between the social representations of mothers and fathers in several intrapersonal functions and no differences in the interpersonal functions.

This research provides important insight regarding the social representations about the functions of deliberate self-harm from adolescents with and without these behaviours and their parents, that can be relevant for clinical intervention and prevention programs.

Keywords: Deliberate Self-Harm; Representations; Functions; Adolescents; Parents

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* Paper submitted to the journal *Psychology & Psychotherapy: Theory, Research and Practice*

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Introduction

Deliberate self-harm encompasses various self-aggressive behaviours, regardless of suicidal intent (Guerreiro et al., 2017; Hawton, et al., 2012; Madge et al., 2008), such as cutting, burning, biting, consuming psychoactive substances, ingesting medication, amongst others.

During the past decades, deliberate self-harm has become more prevalent among adolescents (e.g. Hawton, Saunders & O'Connor, 2012), being nowadays considered a public health concern. In Portugal, where this investigation was conducted, the prevalence rates of deliberate self-harm range from 7.3% to 30% (Carvalho, Motta, Sousa & Cabral, 2017; Gonçalves, Martins, Rosendo, Machado & Silva, 2012; Guerreiro, Sampaio, Figueira & Madge, 2017; Gouveia-Pereira, Gomes, Santos, Frazão & Sampaio, 2016), similarly to several international studies (Brunner et al., 2013; Calvete, Orue, Aizpuru & Brotherton, 2015; Jacobson & Gould, 2007; Muehlenkamp, Claes, Havertap & Plener, 2012).

Research has shown that deliberate self-harm can serve diverse functions (e.g. Nock, 2009). The most frequently studied functions include: affect regulation, anti-dissociation, anti-suicide, interpersonal boundaries, interpersonal influence, self-punishment, and sensation-seeking (Klonsky, 2007). In order to systematize these and other functions, Nock and Prinstein (2004, 2005) proposed the Four Function Model where functions are schematized according to two axis: automatic/social and positive/negative. Thus, automatic negative functions reduce affective states and automatic positive functions create affective states, while social negative functions escape from interpersonal interactions and social positive functions gain attention or reaction from others (Kortge, Meade & Tennant, 2013; Nock & Prinstein, 2004, 2005). Likewise, Klonsky and Glenn (2009) organized many of these functions in their Inventory of Statements about Self-Injury. This instrument contains a scale that evaluates 13 types of functions of deliberate self-harm that also aggregate in a two-dimensional structure (intrapersonal and interpersonal).

In the present investigation, we follow the concept of social representations, as proposed by Moscovici (1961). These representations can be defined as a modality of knowledge that produces and determines behaviours since it defines the nature of the stimuli that surround us and the answers we give them. Hence, social representations can be understood as dynamic sets that aim at the production of social behaviours and interactions, and not only as the mere reproduction of these behaviours and interactions as reactions to external stimuli (Sampaio, Oliveira, Vinagre, Gouveia-Pereira, Santos & Ordaz, 2000). Also,

social representations are simultaneously a product and a process (e.g. Jodelet, 1984; Valsiner, 2003) that allow us to react to certain aspects of reality after interpreting them (Wachelke & Camargo, 2007).

In the context of deliberate self-harm, the knowing, building and modification of social representations and the notion that these representations influence behaviours can be important factors concerning the role of parents and peers. Firstly, as previously stated, these behaviours can have several interpersonal functions besides the most common intrapersonal functions (Muehlenkamp, Brausch, Quigley & Whitlock, 2013). Secondly, parents and peers can be crucial for help-seeking behaviours from the adolescent (Hasking, Rees, Martin & Quigley, 2015; Klineberg, Kelly, Stansfeld & Bhui, 2013; Muehlenkamp et al., 2013; Rowe, French, Henderson, Ougrin, Slade & Moran, 2014), can play a supportive role during treatment (Baetens et al., 2015), and can also contribute to the development of prevention strategies (Berger, Hasking & Martin, 2017).

Although parents and peers have been recognized as important elements, there are considerable limitations to the current knowledge concerning the representations about the functions of deliberate self-harm from adolescents and adults. In general, most studies centered exclusively on the attitudes about deliberate self-harm (e.g. Karman, Kool, Poslawsky & Van Meijel, 2015; McHale & Felton, 2010), utilized samples of adolescents and/or parents that had direct contact with deliberate self-harm (e.g. Ferrey et al., 2016; McDonald, O'Brien & Jackson, 2007), and followed qualitative designs (e.g. Oldershaw, Richards, Simic & Schmidt, 2008; Rissanen, Kylmä & Laukkanen, 2009).

Focusing on adolescents, there are two studies that compared the perspectives from college students about the functions of deliberate self-harm (Batejan, Swenson, Jarvi & Muehlenkamp, 2015; Bresin, Sand & Gordon, 2013). However, in the first study (Batejan et al., 2015) the authors utilized the Inventory of Statements About Self-Injury (Klonsky & Glenn, 2009) and did not differentiate between the perspectives of participants without behaviours and the experiences of participants with behaviours. Additionally, in the second study (Bresin et al., 2013) the authors resourced to fictional vignettes, asking participants to report why they thought the individual engaged in deliberate self-harm behaviours by choosing from six options. These options included four responses based on Nock and Prinstein's Four Function Model (2004, 2005), one response considered the behaviour to be an accident and the other response perceived deliberate self-harm as a suicide attempt. In terms of results, the study from Batejan and colleagues (2015) concluded that the groups did

not differ in their views of the relevance of intrapersonal functions, although non-injuring participants appeared to emphasize some interpersonal functions more than individuals with a history of deliberate self-harm did, and the study from Bresin and colleagues (2013) concluded that there was little differentiation among functions between groups.

Regarding studies that focused on parents, research concluded that these participants commonly report difficulties, struggles and uncertainties in understanding and coping with their children deliberate self-harm (McDonald et al., 2007; Oldershaw et al., 2008), which might suggest their general incomprehension regarding the motivations and functions of deliberate self-harm. If we consider other investigations that utilized samples of adults, namely healthcare workers, some findings suggest that there is a lack of knowledge to signal and deal with self-injury (Bosman & van Meijel, 2008) and that negative attitudes towards self-harmers are connected to the feeling that these behaviours have a manipulative nature (Karman et al., 2015). However, we did not find studies that focused on these adults' comprehension about the functions of deliberate self-harm.

Overview of the Studies

The current article presents two quantitative studies with distinct objectives. Study 1 examines if the social representations about the functions of deliberate self-harm from adolescents without these behaviours are different from the functions represented by adolescents with a history of these behaviours. Study 2 compares the social representations between parents (mothers and fathers) of adolescents with and without deliberate self-harm. Our main goal in both studies is to explore the possible differences regarding the social representations about the several functions of these behaviours (e.g. affect regulation, anti-dissociation or interpersonal influence) and the two dimensions where these functions can be organized (interpersonal and intrapersonal).

Previous findings demonstrate that intrapersonal functions are more common among adolescents with deliberate self-harm (e.g. Klonsky, 2007) and that participants without these behaviours tend to value interpersonal functions (Batejan et al., 2015). Hence, for the first study, we hypothesize that adolescents with a history of deliberate self-harm will significantly emphasize their experience of intrapersonal functions and, on the other hand, adolescents without a history of deliberate self-harm will significantly value interpersonal functions.

Regarding the second study, literature suggests that parents do not have a clear understanding of their children deliberate self-harm behavious (McDonald et al., 2007; Oldershaw et al., 2008). Nonetheless, we hypothesize that significant differences will emerge between the social representations from parents of adolescents with and without deliberate self-harm, and that parents of adolescents without these behaviours will significantly emphasize interpersonal functions (Hypothesis 2).

Study 1: Adolescents' Social Representations about the Functions of Deliberate Self-Harm

Methods

Participants.

The sample consisted of 411 students from two public schools, ranging from the 7th to the 12nd grade. Of this total, 219 (53.3%) were female and 192 (46.7%) were male. The participants' age ranged from 12 to 19 years (M = 15.00, SD = 1.88). Most participants were Portuguese (n = 405, 98.5%); did not flunk any year (n = 348, 84.7%); had one sibling (n = 233, 56.7%), two siblings (n = 74, 18%) or no siblings (n = 72, 17.5%); and had married (n = 267, 65%) or divorced parents (n = 85, 20.7%). Of the 411 adolescents, 109 (26.5%) mentioned having practiced at least one self-harm behaviour during their life.

Measures.

Inventory of Deliberate Self-Harm Behaviours. The Inventory of Deliberate Self-Harm Behaviours was validated for Portuguese adolescents by Duarte, Gouveia-Pereira and Sampaio (in press-c). It consists of an adaptation of the first section of the Inventory of Statements about Self-Injury (Klonsky & Glenn, 2009) and has revealed acceptable psychometric properties.

This instrument presents 13 different self-harm behaviours: cutting, biting, burning, pulling hair, scratching until the skin is wounded, consuming drugs with a self-aggressive intent, inserting needles in the skin, ingesting dangerous substances with a self-aggressive intent, drinking alcohol with a self-aggressive intent, banging/hitting, ingesting medication with a self-aggressive intent, ingesting medication with a suicidal intent, and attempting suicide. The respondent is asked to sign the absence or lifetime frequency of each method of self-harm ("No", "Yes – 1 Time", "Yes, 2-10 Times", "Yes, More than 10 Times").

Questionnaire of Representations About the Functions of Deliberate Self-Harm for Adolescents. This questionnaire was validated to Portuguese adolescents and presented acceptable psychometric properties (Duarte, Gouveia-Pereira, Gomes & Sampaio, in press-a). It incorporates items from three different sources: the translation of the second section of the Inventory of Statements About Self-Injury (Klonsky & Glenn, 2009), items that resulted from the analysis of interviews and items that emerged from the analysis of Portuguese written press.

This instrument begin with a short introduction mentioning that some young people have deliberate self-harm. In order to differentiate between the assessment of the social representations from adolescents without deliberate self-harm and the assessment of the functions' experience of adolescents with a history of these behaviours, it was added a note mentioning that "If you practiced any of these behaviours, please answer according to your experience". The sentence "When young people have these behaviours, they are..." precedes the items and the answers are organized on a five point Likert scale: totally disagree, disagree, neither, agree, or totally agree.

This questionnaire comprises 35 items that evaluate the experiences and representations about 11 functions of deliberate self-harm, which can be categorized according to two dimensions (interpersonal and intrapersonal functions). The interpersonal dimension (α = .84, M = 2.66, SD = 0.59) includes Autonomy & Toughness (e.g. item 24 "Demonstrating they are tough or strong"; α = .75, M = 2.58, SD = 0.73), Interpersonal Boundaries (e.g. item 1 "Creating a boundary between themselves and others"; α = .83, M = 3.09, SD = 0.99), Interpersonal Influence (e.g. item 7 "Seeking care or help from others"; α = .73, M = 2.92, SD = 0.91), Peer Bonding (e.g. item 11 "Trying to fit in with others"; α = .70, M = 2.38, SD = 0.92) and Revenge (e.g. item 14 "Trying to hurt someone close to them"; α = .73, M = 2.34, SD = 0.90). The intrapersonal dimension (α = .90, M = 3.36, SD = 0.63) includes Affect Regulation (e.g. item 10 "Reducing their anxiety, frustration, anger, or other emotions"; α = .71, M = 3.73, SD = 0.80), Anti-Dissociation (e.g. item 27 "Inflicting pain in order to feel something"; α = .81, M = 2.95, SD = 0.83), Escape Mechanism (e.g. item 19 "Escaping from problems"; α = .85, M = 3.49, SD = 0.89), Introspective Mechanism (e.g. item 17 "Organizing their ideas"; α = .76, M = 2.59, SD = 0.96), Replacement of Suffering (e.g. item 18 "Creating physical pain to forget the psychological pain"; α = .92, M = 3.67, SD = 0.93) and Self-Punishment (e.g. item 25 "Doing it because they feel guilty"; α = .68, M = 3.59, SD = 0.84).

Socio-Demographic Questionnaire. The adolescents responded to questions regarding their age, gender, nationality, education (number of flunks and school grade), the existence of siblings, and marital status of their parents.

Procedures.

This study was approved by the General Education Directorate of the Ministry of Education and Science. The schools were contacted and informed about the objectives of the investigation. After receiving the schools' administration approval, several classes were selected. In a first moment, the researcher delivered the consent forms to the students' parents/legal guardians. In a second moment, the students whose parents/legal guardians signed the consent form completed the questionnaire. All the adolescents were informed that their collaboration was voluntary and that the collected data was anonymous and confidential.

Data Analysis.

The statistical analyses were performed using SPSS v22 software (IBM SPSS, Chicago, IL). Descriptive statistics were used to analyze socio-demographic data, as well as deliberate self-harm lifetime prevalence and frequency of the self-harm methods. To examine group differences we utilized Student-t Test.

Results

Deliberate Self-Harm Prevalence.

As previously mentioned, of the 411 adolescents, 109 (26.5%) reported having practiced at least one self-harm behaviour. Banging/hitting was the most practiced method (n = 63, 15.4%), followed by biting (n = 59, 14.4%), cutting (n = 50, 12.2%), pulling hair (n = 44, 10.7%), scratching until the skin is wounded (n = 40, 9.8%), burning (n = 27, 6.5%), inserting needles in the skin (n = 16, 3.8%), drinking alcohol with a self-aggressive intent (n = 15, 3.6%), consuming drugs with a self-aggressive intent (n = 14, 3.3%), ingesting medication with a self-aggressive intent (n = 12, 2.9%), attempting suicide (n = 8, 1.9%), ingesting medication with a suicidal intent (n = 6, 1.5%), and ingesting dangerous substances with a self-aggressive intent (n = 6, 1.5%). Participants who reported deliberate self-harm endorsed an average of 3.28 methods (SD = 2.13).

Social Representations About the Functions of Deliberate Self-Harm.

This study examined if the social representations about the functions of deliberate self-harm from adolescents without these behaviours were different from the functions represented by adolescents with a history of these behaviours (Table 1). Regarding the interpersonal dimension, results indicate that the group of adolescents without deliberate self-harm significantly emphasized the global interpersonal dimension (t = 3.61, p < .001) and the functions Interpersonal Boundaries (t = 3.81, p < .001), Interpersonal Influence (t = 2.05, p < .05), Peer Bonding (t = 3.27, p < .01) and Revenge (t = 2.81, p < .01). Also, there were marginally significant differences in the function Autonomy & Toughness (t = 1.69, p < .1), where adolescents without deliberate self-harm slightly valued this function.

In the intrapersonal dimension, adolescents with deliberate self-harm emphasized Affect Regulation (t = -4.38, p < .001) and presented marginally significant higher means concerning the function Replacement of Suffering (t = -1.85, p < .1) and the global intrapersonal dimension (t = -1.86, p < .1).

Table 1. Comparison of function mean scores between adolescents without deliberate self-harm (DSH) and adolescents with DSH (N = 411)

	Adolescents without DSH (n = 302)	Adolescents with DSH (n = 109)	t
Interpersonal Dimension	2.72	2.49	3.61***
Autonomy & Toughness	2.62	2.48	1.69†
Interpersonal Boundaries	3.19	2.78	3.81***
Interpersonal Influence	2.95	2.77	2.05*
Peer Bonding	2.47	2.13	3.27**
Revenge	2.41	2.13	2.81**
Intrapersonal Dimension	3.33	3.46	-1.86†
Affect Regulation	3.63	4.02	-4.38***
Anti-Dissociation	n.s.	n.s.	n.s.
Escape Mechanism	n.s.	n.s.	n.s.
Introspective Mechanism	n.s.	n.s.	n.s.
Replacement of Suffering	3.62	3.82	-1.85†
Self-Punishment	n.s.	n.s.	n.s.

Note. n.s. non-significant; † marginally significant at .1 level; * Significant at .05 level; ** significant at .01 level; *** significant at .001 level.

Overall, results demonstrated differences between all the interpersonal functions and in two intrapersonal functions. In these intrapersonal functions, the means from adolescents with deliberate self-harm were considerably higher than in other functions (Affect Regulation, M = 4.02; Replacement of Suffering, M = 3.82). However, no significant differences were found in the intrapersonal functions Anti-Dissociation, Escape Mechanism, Replacement of Suffering and Self-Punishment.

Study 2: Parents' Social Representations about the Functions of Deliberate Self-Harm.

Methods

Participants.

Our sample consisted of 471 participants, 265 mothers and 206 fathers, with ages between 33 and 62 years old (M = 45.96, SD = 5.46). Participants were mostly Portuguese (n = 467, 99.2%); had a college/university degree (n = 151, 34.5%), studied from 10th to 12nd grade (n = 140, 32%) or from 7th to 9th grade (n = 90, 20.6%); were married (n = 374, 79.7%); and had an average of two children (M = 2.10, SD = 1.16).

Regarding their children deliberate self-harm behaviours, of 471 parents, 120 (25.5%, 69 mothers and 51 fathers) had children who reported having these behaviours. Nonetheless, only 12 parents (2.5% of the total sample and 10% of the parents of adolescents with deliberate self-harm) stated they had knowledge that their child self-harmed (nine mothers and three fathers).

Measures.

Inventory of Deliberate Self-Harm Behaviours. This instrument was previouly utilized in Study 1. Although this instrument is directed to adolescents (Duarte et al., in press-c), in the current study we utilized it as a tool to assess parents' knowledge about their children deliberate self-harm behaviours. Therefore, the respondents were asked to sign the absence or lifetime frequency of each method of self-harm for their child.

Questionnaire of Representations About the Functions of Deliberate Self-Harm for Adults. This questionnaire contains items from three different sources: the translation of the second section of the Inventory of Statements About Self-Injury (Klonsky & Glenn, 2009), items that resulted from the analysis of interviews and items that emerged from the analysis of

Portuguese written press. It has been validated to Portuguese adults (Duarte, Gouveia-Pereira, Gomes & Sampaio, in press-b) and revealed acceptable psychometric properties.

This instrument begins with a short introduction mentioning that some adolescents have deliberate self-harm. The items are preceded by the sentence "When young people have these behaviours, they are...". The answers are presented on a five point Likert scale: totally disagree, disagree, neither, agree, or totally agree.

The questionnaire presents 49 items that assess the representations about 14 functions of deliberate self-harm, which can be organized in two dimensions (interpersonal and intrapersonal). The interpersonal dimension (α = .95, M = 3.03, SD = 0.63) includes Autonomy & Toughness (e.g. item 29 "Demonstrating they are autonomous or independent"; α = .89, M = 2.63, SD = 0.79), Interpersonal Boundaries (e.g. item 22 "Establishing a barrier between themselves and others"; α = .76, M = 2.73, SD = 0.91), Interpersonal Influence (e.g. item 17 "Seeking care or help from others"; α = .82, M = 3.38, SD = 0.79), Peer Bonding (e.g. item 36 "Trying to belong to a group of friends/colleagues"; α = .76, M = 2.58, SD = 0.81) and Revenge (e.g. item 10 "Getting revenge from someone"; α = .73, M = 2.79, SD = 0.91). The intrapersonal dimension (α = .91, M = 2.84, SD = 0.64) includes Affect Regulation (e.g. item 1 "Calming themselves down"; α = .72, M = 2.97, SD = 0.84), Anti-Dissociation (e.g. item 14 "Trying to feel something instead of nothing, even if it is physical pain"; α = .79, M = 2.92, SD = 0.86), Anti-Suicide (e.g. item 15 "Reacting to suicidal thoughts without attempting suicide"; α = .80, M = 2.69, SD = 0.78), Escape Mechanism (e.g. item 43 "Escaping from something that is not right"; α = .76, M = 3.22, SD = 0.82), Introspective Mechanism (e.g. item 34 "Isolating themselves in their thoughts"; α = .81, M = 2.90, SD = 0.76), Marking Distress (e.g. item 19 "Proving themselves that their emotional pain is real"; α = .68, M = 3.15, SD = 0.84), Replacement of Suffering (e.g. item 44 "Physically responding to an emotional pain"; α = .91, M = 3.40, SD = 0.87), Self-Care (e.g. item 23 "Focusing on treating the injury, which can be gratifying or satisfying"; α = .61, M = 2.63, SD = 0.97) and Self-Punishment (e.g. item 13 "Demonstrating the anger they feel for themselves"; α = .87, M = 3.17, SD = 0.76).

Socio-Demographic Questionnaire. The socio-demographic questionnaire for parents included items about their age, nationality, education level, marital status and number of children.

Procedures.

We contacted several schools, informed them about the aim of our research and asked for administration authorization. Afterwards, the schools that were available to cooperate with the investigation selected several classes. In a first moment, the researcher delivered the parents' questionnaires to students. These questionnaires were sent in an envelope, along with a letter informing parents that both mother and father should respond separately and return the questionnaires in the closed envelope to their child, even if they did not complete the questionnaire. In a second moment, the students brought back their parents' questionnaires and gave them to the researcher. All the participants were informed that their collaboration was voluntary and that the collected data was totally anonymous and confidential.

Data Analysis.

All statistical analyses were carried out using SPSS v22 software (IBM SPSS, Chicago, IL). Descriptive statistics were used to analyze socio-demographic data. This study has an intergroup design and therefore, in order to examine the differences from the four groups simultaneously (mothers and fathers of adolescents with and without deliberate self-harm), we utilized One-way ANOVA.

Results

In this study, we explored the differences between the social representations about the functions of deliberate self-harm from mothers and fathers of adolescents with and without these behaviours, comprising four groups of participants. Results did not reveal differences in the interpersonal dimension, and revealed significant differences between the four groups of parents in the intrapersonal dimension (Table 2).

Focusing on the intrapersonal dimension, there were no significant differences in the functions Affect Regulation, Escape Mechanism and Self-Care. However, results revealed considerable differences in six functions and in the global intrapersonal dimension. Firstly, mothers of adolescents with deliberate self-harm emphasized the global intrapersonal dimension ($F = 5.39$, $p = .01$), and the functions Anti-Suicide ($F = 3.72$, $p = .05$) and Self-Punishment ($F = 4.07$, $p = .01$) significantly more than fathers of adolescents with and without deliberate self-harm. This group of mothers of adolescents with deliberate self-harm also significantly emphasized the functions Introspective Mechanism ($F = 2.95$, $p = .05$) and Marking Distress ($F = 3.11$, $p = .05$) when compared to the group of fathers of adolescents

with deliberate self-harm.

Considering the functions Anti-Dissociation (F = 6.47, p = .001) and Replacement of Suffering (F = 7.06, p = .001), results revealed the following significant differences: a) mothers of adolescents with deliberate self-harm emphasized these functions more than fathers of adolescents with and without self-harm; b) mothers of adolescents without deliberate self-harm emphasized these functions more than fathers of adolescents with deliberate self-harm.

In addition, as it is observable in Table 2, the fathers of adolescents with deliberate self-harm were the group that presented lower means in all the intrapersonal functions were differences emerged, followed by the group of fathers of adolescents without behaviours.

Table 2. Comparison of function mean scores between parents of adolescents without deliberate self-harm (DSH) and parents of adolescents with DSH (N = 471)

	Parents of Adolescents Without DSH		Parents of Adolescents With DSH		
	Mothers (n = 196)	Fathers (n = 155)	Mothers (n = 69)	Fathers (n = 51)	F
Interpersonal Dimension	n.s.	n.s.	n.s.	n.s.	n.s.
Autonomy & Toughness	n.s.	n.s.	n.s.	n.s.	n.s.
Interpersonal Boundaries	n.s.	n.s.	n.s.	n.s.	n.s.
Interpersonal Influence	n.s.	n.s.	n.s.	n.s.	n.s.
Peer Bonding	n.s.	n.s.	n.s.	n.s.	n.s.
Revenge	n.s.	n.s.	n.s.	n.s.	n.s.
Intrapersonal Dimension	$3.08^{a,b}$	2.97^{a}	3.25^{b}	2.83^{a}	5.39^{**}
Affect Regulation	n.s.	n.s.	n.s.	n.s.	n.s.
Anti-Dissociation	$2.97^{a,b}$	$2.81^{a,c}$	3.24^{b}	2.63^{c}	6.47^{***}
Anti-Suicide	$2.68^{a,b}$	2.63^{a}	2.95^{b}	2.53^{a}	3.72^{*}
Escape Mechanism	n.s.	n.s.	n.s.	n.s.	n.s.
Introspective Mechanism	$2.93^{a,b}$	$2.84^{a,b}$	3.08^{a}	2.70^{b}	2.95^{*}
Marking Distress	$3.16^{a,b}$	$3.11^{a,b}$	3.39^{a}	2.94^{b}	3.11^{*}
Replacement of Suffering	$3.45^{a,b}$	$3.30^{a,c}$	3.75^{b}	3.08^{c}	7.06^{***}
Self-Care	n.s.	n.s.	n.s.	n.s.	n.s.
Self-Punishment	$3.22^{a,b}$	3.08^{a}	3.37^{b}	2.94^{a}	4.07^{**}

Note. $^{n.s.}$ non-significant; * Significant at .05 level; ** significant at .01 level; *** significant at .001 level. Each superscript letter denotes a subset of each function, different letters represent statistically significant differences between columns.

However, it is important to underline that there were no significant differences in the interpersonal dimension and its functions, which means that the social representations from the four groups of parents were similar.

General Discussion

This investigation aimed to describe and compare the social representations about the functions of deliberate self-harm from adolescents with and without these behaviours, and to compare the social representations from parents of adolescents with and without these behaviours. Hence, we developed two studies: between adolescents with and without deliberate self-harm (Study 1) and between parents (mothers and fathers) of adolescents with and without deliberate self-harm (Study 2).

In a first moment, we conducted a descriptive analysis of deliberate self-harm lifetime prevalence and methods in our total adolescent sample. Of 411 adolescents, 109 (26.5%) reported having practiced at least one behaviour. This rate is similar to those found in other Portuguese studies (Carvalho et al., 2017; Duarte et al., in press-c; Gonçalves et al., 2012) and international studies (e.g. Brunner et al., 2013; Muehlenkamp et al., 2012). Regarding methods, banging/hitting was the most common method, followed by biting and cutting, which is in accordance with results from studies that utilized identical samples (Brunner et al., 2013; Calvete et al., 2015; Carvalho et al., 2017; Gonçalves et al., 2012; Gouveia-Pereira et al., 2016; Madge et al., 2008; Nixon, Cloutier & Jansson, 2008).

Regarding the social representations about the functions of self-harm, several differences emerged in our analyses. In the first study, where we compared the representations of adolescents without deliberate self-harm and the functions reported by adolescents with a history of deliberate self-harm, results demonstrated that all the interpersonal functions presented significant differences. Adolescents without these behaviours emphasized all the interpersonal functions (Autonomy & Toughness, Interpersonal Boundaries, Interpersonal Influence, Peer Bonding and Revenge). Oppositely, adolescents with a history of self-harm behaviours emphasized two intrapersonal functions (Affect Regulation and Replacement of Suffering). However, the differences for the function Replacement of Suffering were marginally significant, which means that the only intrapersonal function that revealed considerable divergences was, in fact, Affect Regulation.

For this study, we had hypothesized that adolescents with a history of deliberate self-harm would emphasize their experience of intrapersonal functions and, on the other hand, adolescents without a history of deliberate self-harm would value interpersonal functions (Hypothesis 1). In general, results confirmed this hypothesis, especially because there were significant differences in the interpersonal functions and adolescents without deliberate self-harm emphasized all these functions. However, as previously mentioned, there were little differences in the intrapersonal functions, which partially contradicts our hypothesis. The only intrapersonal function that was significantly emphasized by adolescents with deliberate self-harm was Affect Regulation.

If we observe the mean of the function Affect Regulation (M = 4.02), it is clear that this was the most valued function by the group of adolescents without deliberate self-harm. This result is in accordance with the notion that this is the most common function among adolescents with deliberate self-harm (e.g. Klonsky, 2007). Hence, it is possible to conclude that, although the social representations from adolescents without these behaviours are similar to the social representations of adolescents with these behaviours in the intrapersonal dimension, they do not recognize the importance of Affect Regulation.

These findings are somewhat similar to those found in previous research (Bresin et al., 2013; Duarte, Gouveia-Pereira & Sampaio, in press-d) and specifically in the study conducted by Batejan and colleagues (2015). The discrepancies between the social representations from adolescents without these behaviours and the social representations of adolescents with deliberate self-harm imply that the personal experience of deliberate self-harm builds and/or changes the social representations from adolescents. In addition, the emphasis that adolescents withouth deliberate self-harm gave to the interpersonal functions demonstrates that their social representations are influenced by the stereotypical idea that these behaviours have a manipulatory nature (Law, Rostill-Brookes and Goodman, 2009), and are directed towards others (i.e. a bond with friends, a call for attention, or an attempt to obtain revenge). Regarding the intrapersonal functions, we hypothesize that this similarity between the social representations of adolescents without behaviours and social representations of adolescentes with deliberate self-harm may be connected to their age proximity, and also to their belonging to a social group that might share self-harm experiences and communicate about them. Therefore, it is possible that the adolescents with deliberate self-harm talk with their close peers about the importance that intrapersonal functions have for their practices but that, on the other hand, they do not mention or devalue interpersonal functions (which justifies the emphasis adolescents without behaviours give to these functions).

Our second study focused on the comparison between the representations from mothers and fathers of adolescents with and without deliberate self-harm. Results did not reveal any significant differences in the interpersonal dimension between parents of adolescents with and without these behaviours, which implies that parents' social representations were similar.

Regarding the intrapersonal dimension, our findings demonstrated that there were no significant differences in the functions Affect Regulation, Escape Mechanism and Self-Care. Nonetheless, various significant differences emerged between mothers and fathers. Specifically, results demonstrated that: a) mothers of adolescents with deliberate self-harm emphasized the functions Anti-Suicide and Self-Punishment more than fathers of adolescents with and without deliberate self-harm; b) mothers of adolescents with deliberate self-harm emphasized the functions Introspective Mechanism and Marking Distress when compared to the group of fathers of adolescents with deliberate self-harm; c) mothers of adolescents with deliberate self-harm emphasized the functions Anti-Dissociation and Replacement of Suffering more than fathers of adolescents with and without self-harm; d) mothers of adolescents without deliberate self-harm also emphasized Anti-Dissociation and Replacement of Suffering more than fathers of adolescents with deliberate self-harm.

Our hypothesis for this study was that differences would emerge between parents of adolescents with and without self-harm, and that parents of adolescents without these behaviours would emphasize interpersonal functions (Hypothesis 2). Although we did not find significant differences in the interpersonal functions, our results partially confirm this hypothesis, since discrepancies emerged in the intrapersonal functions. Despite the fact we were expecting differences between the groups of parents of adolescents with and without these behaviours, our findings demonstrated that differences existed betwen mothers and fathers, regardless of adolescents' behaviours. Mothers' social representations emphasized several intrapersonal functions, and these functions are more commonly endorsed by adolescents with deliberate self-harm (e.g. Klonsky, 2007). Hence, we think this result may be connected to the fact that mothers usually have closer relationships with their children when compared to fathers (e.g. Collins & Russell, 1991; Doyle, Lawford & Markiewicz, 2009; Markiewicz, Lawford, Doyle & Haggart, 2006; Tsai, Telzer, & Fuligni, 2013).

On the other hand, the lack of differences in the interpersonal functions between parents from adolescents with and without deliberate self-harm is also relevant. It demonstrates that the mere presence of deliberate self-harm in a family does not imply

different parental social representations, although we were not able to differentiate between parents who were aware of the adolescents' behaviours and those who were not due to insufficient data (only 12 parents had knowledge of their children behaviours). Hence, we consider that gender and the possible proximity with the adolescents may be relevant to the construction of these representations.

Globally, our findings can have some important implications for clinical and prevention contexts. Regarding the differences between the social representations from adolescents, the discrepancies we found can have a negative impact, mostly because peers can be a risk factor or a protective factor for these behaviours (e.g. Evans, Hawton & Rodham, 2005; Heath, Ross, Toste, Charlebois & Nedecheva, 2009). For example, if peers are aware of the reasons for engaging in deliberate self-harm, they can play a supportive role in the clinical work (Bresin et al., 2013). On the other hand, peers have revealed a lack of empathy and information when confronted with deliberate self-harm (Hasking et al., 2015), which can aggravate the practice of these behaviours. Therefore, educating peers about the functions of deliberate self-harm may dispel negative stigmas (Batejan et al., 2015) and contribute to the modification of their social representations concerning this phenomenon. In terms of the differences found in the groups of parents, our results globally revealed that mothers tend to value intrapersonal functions more than fathers, which are usually more endorsed by adolescents with deliberate self-harm than the interpersonal functions. This finding indicates that mothers can possibly be key elements during clinical interventions with these adolescents, and that fathers should be a greater focus of attention in terms of psychoeducation.

Limitations and Directions for Future Research

Although our research provided important insight regarding the social representations of the functions of deliberate self-harm, using instruments that were previously adapted and validated to assess these representations, there are some limitations that should be noted. The generalizability of our results may be limited by our use of a college student sample and their parents. In addition, we were not able to differentiate between parents who were aware of their children self-harm behaviours and those who did not, which could clarify parental social representations.

Since deliberate self-harm is increasing in adolescence (e.g. Hawton et al., 2012) and the study of its representations can be relevant for intervention and prevention programs,

further research is clearly needed in this area. There is still limited information regarding the representations of individuals that did not have direct contact with these behaviours and most existing investigations followed a qualitative approach. Future research could explore and describe these representations, namely from teachers and other school staff, healthcare workers, and adolescents and adults with different social and cultural backgrounds. Also, we consider important to study familial representations through paired samples' studies, focusing on the comparison of families of adolescents with and without deliberate self-harm, and between parents that are aware of their children deliberate self-harm and those who are not.

In addition, we consider that longitudinal studies that evaluate the possible changes of these social representations during time would also be an interesting approach. Furthermore, it would be interesting to study the possible relation of these representations with other variables, such as psychopathology, suicidal ideation, or religious beliefs.

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How do Families Represent the Functions of Deliberate Self-Harm?: A Comparison Between the Social Representations from Adolescents and Their Parents*

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Abstract

Research has recognized the importance of understanding the social representations about the functions of deliberate self-harm, particularly in the context of clinical intervention. In addition, parents can play a relevant role in the rehabilitation of adolescents with these behaviours. However, there are few studies that focused on the description and comparison of the social representations about these functions, particularly in families.

This article aimed to analyze the social representations about the functions of deliberate self-harm from adolescents and parents. We developed two sets of analysis: first we compared the social representations from adolescents without a history of deliberate self-harm and their parents, and secondly we compared the social representations about the functions of deliberate self-harm from adolescents with a history of these behaviours and their parents' social representations.

Results revealed significant differences between both groups of families, implying that the groups of participants represent the functions of deliberate self-harm differently. Overall, parents emphasized interpersonal functions and devalued intrapersonal functions. These differences were accentuated in the families of adolescents with deliberate self-harm.

The present article provides important insight regarding the social representations about the functions of deliberate self-harm and the differences between parents' social representations and their children experiences and social representations.

Keywords: Deliberate Self-Harm; Social Representations; Functions; Adolescents; Parents; Family

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* Paper submitted to the journal *Archives of Suicide Research*

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Introduction

Deliberate self-harm is quite prevalent among adolescents and young adults, being nowadays considered a public health problem. During the last decades the rates of these behaviours have increased (e.g. Hawton, Saunders & O'Connor, 2012), with a lifetime prevalence in adolescents that range from 7.3% to 30% (Brunner et al., 2013; Calvete, Orue, Aizpuru & Brotherton, 2015; Carvalho, Motta, Sousa & Cabral, 2017; Gonçalves, Martins, Rosendo, Machado & Silva, 2012; Gouveia-Pereira, Gomes, Santos, Frazão & Sampaio, 2016; Guerreiro, Sampaio, Figueira & Madge, 2017; Jacobson & Gould, 2007; Muehlenkamp, Claes, Havertap & Plener, 2012). Deliberate self-harm encompasses various self-aggressive behaviours, regardless of suicidal intent (Guerreiro et al., 2017; Hawton et al., 2012; Madge et al., 2008), namely cutting, burning, biting, consuming psychoactive substances (such as alcohol or drugs), ingesting medication, and others.

The knowledge about the functions of deliberate self-harm is one of the most important factors in this context, since it can contribute to the understanding of this phenomenon's etiology, as well as to its classification, prevention and treatment (Klonsky, 2007). It is known that deliberate self-harm can serve diverse functions that can occur simultaneously (Lloyd-Richardson, 2008; Nock, 2009; Saraff, Trujillo & Pepper, 2015). According to Klonsky (2007), the most frequently studied functions include: Affect Regulation, Anti-Dissociation, Anti-Suicide, Interpersonal Boundaries, Interpersonal Influence, Self-Punishment, and Sensation-Seeking. Nonetheless, there are also other less common functions, such as Autonomy (Klonsky & Glenn, 2009), Peer Bonding (Klonsky & Glenn, 2009), Revenge (Klonsky, 2007; Rabi, Sulochana & Pawan, 2017; Rodham, Hawton & Evans, 2004), or Self-Care (Klonsky & Glenn, 2009).

In order to systematize the many functions of deliberate self-harm, Nock and Prinstein (2004, 2005) proposed the Four Function Model where they categorized functions in two axis: automatic/social and positive/negative. According to this model, automatic negative functions reduce affective states and automatic positive functions create affective states, while social negative functions allow escape from interpersonal interactions and social positive functions contribute to gain attention or to trigger some reaction from others (Kortge, Meade & Tennant, 2013; Nock & Prinstein, 2004, 2005). Hence, the functions of deliberate self-harm can also be organized according to their interpersonal (social) or intrapersonal (automatic) nature. Recently, research has recognized the importance of the interpersonal functions, although they are less common than the intrapersonal functions (Heath, Ross, Toste,

Charlebois & Nedecheva, 2009; Muehlenkamp, Brausch, Quigley & Whitlock, 2013).

Knowing and understanding the functions of deliberate self-harm is crucial for supportive and effective responses to individuals' disclosures of self-harm (Muehlenkamp et al., 2013). For example, if friends and family members have an inaccurate understanding of these functions (e.g., believing the behaviour to be an act of manipulation instead of a form of support-seeking), it may lead to responses that inadvertently aggravate the frequency and severity of the behaviours (Bresin, Sand & Gordon, 2013). Hence, comprehending the representations about the functions of deliberate self-harm may have important implications for clinical interventions and prevention programs, particularly in terms of social support.

Social representations are a modality of knowledge that produces and determines behaviours because they define the nature of the stimuli that surround us and the answers we give them (Moscovici, 1961). These representations can be understood as dynamic sets that aim at the production of social behaviours and interactions, and not only as the mere reproduction of these behaviours and interactions as reactions to external stimuli (Sampaio, Oliveira, Vinagre, Gouveia-Pereira, Santos & Ordaz, 2000). Hence, social representations are simultaneously a product and a process (e.g. Jodelet, 1984; Valsiner, 2003) that allow us to interpret aspects of reality to further react to them (Wachelke & Camargo, 2007).

Family, specifically parents, have been recognized as an important factor within the context of deliberate self-harm (e.g. Arbuthnott & Lewis, 2015; Hasking, Rees, Martin & Quigley, 2015; Santos, 2007). Family seems to occupy a central role in clinical intervention and research suggests that it is necessary to incorporate family therapy into treatments, particularly interventions that work towards strengthening communication and emotional support (Muehlenkamp et al., 2013). Additionally, a caring and affectionate family environment, where space for the discussion of these behaviours exist, can favour the adolescent's rehabilitation process (Arbuthnott & Lewis, 2015).

Research has focused on the risk factors associated with parents, help-seeking from parents, interventions involving parents and impact on parent well-being (Arbuthnott & Lewis, 2015). Also, several studies explored the views and attitudes of parents of adolescents who self-harm (Ferrey et al., 2016; McDonald, O'Brien & Jackson, 2007; Oldershaw, Richards, Simic & Schmidt, 2008; Rissanen, Kylmä & Laukkanen, 2008, 2009), but did not focus on the representations of these behaviours' functions. Oldershaw and colleagues (2008), for example, concluded that parents commonly suspected and spotted self-harm prior to disclosure or service contact, but also concluded that communication difficulties and

underestimating significance led to delays in addressing the behaviour. The study developed by Ferrey et al (2016) found that, after the discovery of self-harm, parents described initial feelings of shock, anger and disbelief, and later reactions of stress, anxiety, feelings of guilt and in some cases the onset or worsening of clinical depression. Also, parents frequently emphasize their difficulties, struggles and uncertainties in understanding and coping with their children deliberate self-harm (McDonald et al., 2007; Oldershaw et al., 2008).

There are several limitations to the current knowledge concerning the representations about the functions of deliberate self-harm from adolescents and parents, since most studies centered on the attitudes about deliberate self-harm and utilized samples of adolescents and/or parents that had direct contact with these behaviours. Moreover, we did not find any studies that compared the social representations and experiences from adolescents with and without deliberate self-harm and their parents. The few studies that compared the perspectives about the functions of deliberate self-harm of participants with and without a history of these behaviours focused on the views of college students (Batejan, Swenson, Jarvi & Muehlenkamp, 2015; Bresin et al., 2013). The first mentioned study concluded that the groups did not differ in their views of the relevance of intrapersonal functions, although non-injuring participants appeared to stress some interpersonal functions slightly more than individuals with a history of deliberate self-harm did (Batejan et al., 2015), and the study from Bresin and colleagues (2013) concluded that there was little differentiation among functions between groups.

The Current Study

We consider important to study the social representations about the functions of deliberate self-harm from adolescents with and without direct experience of these behaviours and their parents. Moreover, the study of these social representations and experiences can contribute to the understanding of the social representations from families of adolescents with and without deliberate self-harm.

Hence, the objective of the current article focuses on the comparison of the social representations about the functions of deliberate self-harm from families (adolescent, mother and father) of adolescents with and without these behaviours. We developed two sets of analysis: a) the first one compares the social representations about the functions of deliberate self-harm from adolescents without a history of these behaviours and their parents' social representations; b) the second one compares the functions mentioned by adolescents with a

history of deliberate self-harm and their parents' social representations about these functions. Our main goal is to explore the possible differences regarding the social representations about the several functions of these behaviours (e.g. Affect Regulation, Anti-Dissociation or Interpersonal Influence) and the two dimensions where these functions can be organized (interpersonal and intrapersonal).

Research has shown the global incomprehension of parents regarding the motivations and functions of deliberate self-harm (e.g. McDonald et al., 2007; Oldershaw et al., 2008). Also, a previous study (Batejan et al., 2015) concluded that participants without deliberate self-harm appeared to value some interpersonal functions more than participants with a history of these behaviours did. For the first set of analysis, we hypothesize that there will be no significant differences between adults and adolescents concerning the interpersonal dimension, and that significant differences will emerge in the intrapersonal dimension, where adolescents will emphasize these functions (Hypothesis 1). Also, since previous findings suggest that mothers maintain closer relationships with their children (e.g. Collins & Russell, 1991; Doyle, Lawford & Markiewicz, 2009; Markiewicz, Lawford, Doyle & Haggart, 2006; Tsai, Telzer, & Fuligni, 2013), we present a second hypothesis for this set of analyses. If differences emerge between the parents of adolescents without deliberate self-harm, we hypothesize that mothers' social representations will be more similar to the adolescents' social representations (Hypothesis 2).

For the second set of analysis, previous studies revealed that intrapersonal functions are more common among adolescents with deliberate self-harm (e.g. Klonsky, 2007) and that participants without these behaviours tend to value interpersonal functions (Batejan et al., 2015). Hence, the social representations based on the experience of these behaviours' functions should be different from parents' social representations. We hypothesize that adolescents with a history of deliberate self-harm will emphasize their experience of intrapersonal functions and, on the contrary, parents will value more interpersonal functions than these adolescents (Hypothesis 3). Similarly to the first set of analysis, we defined one more hypothesis based on the assumption that mothers maintain closer relationships with their children (e.g. Collins & Russell, 1991; Doyle et al., 2009; Markiewicz et al., 2006; Tsai et al., 2013). Hence, if differences emerge between the parents of adolescents with deliberate self-harm, we hypothesize that mothers' social representations will be more similar to the adolescents' experiences (Hypothesis 4).

Methods

Participants

The participants of this study are part of a bigger sample collected during a doctoral thesis investigation. In order to allow the comparison of the representations of family triads, we selected the families were all three elements had completed the questionnaire (adolescent, mother and father). Hence, the present sample consisted of a total of 203 families, including 152 families of adolescents without a history of deliberate self-harm and 51 families of adolescents with a history of these behaviours.

In total, these families corresponded to 609 participants: 203 adolescents, 203 mothers and 203 fathers. Parents had ages between 33 and 60 years old (M = 46.02, SD = 5.49); were mostly Portuguese (n = 403, 99.3%); had a college/university degree (n = 130, 32%), studied from 10th to 12nd grade (n = 117, 28.9%) or from 7th to 9th grade (n = 79, 19.4%); were married (n = 357, 87.9%); and had an average of two children (M = 2.11, SD = 0.99). Regarding their children deliberate self-harm behaviours, 102 parents (25.1%) had children who reported having these behaviours. Nonetheless, only eight parents (2% of the total sample) stated they had knowledge that their child self-harmed (five mothers and three fathers).

The sample of adolescents comprised 203 participants, 51 (25.1%) of which reported deliberate self-harm. From this total, 110 participants (54.2%) were female and 93 (45.8%) were male, and their age ranged from 12 to 19 years (M = 14.70, SD = 1.78). Most adolescents were Portuguese (n = 201, 99%); did not flunk any year (n = 182, 89.7%); had one sibling (n = 124, 61.1%), two siblings (n = 31, 15.3%) or no siblings (n = 34, 16.7%); and had married parents (n = 170, 84.2%).

Measures

Inventory of Deliberate Self-Harm Behaviours.

The Inventory of Deliberate Self-Harm Behaviours is an adaptation of the first section of the Inventory of Statements about Self-Injury (Klonsky & Glenn, 2009). It has been validated for Portuguese adolescents by Duarte, Gouveia-Pereira and Sampaio (in press-d) and has revealed good psychometric properties.

This inventory presents 13 different self-harm behaviours: cutting, biting, burning, pulling hair, scratching until the skin is wounded, consuming drugs with a self-aggressive

intent, inserting needles in the skin, ingesting dangerous substances with a self-aggressive intent, drinking alcohol with a self-aggressive intent, banging/hitting, ingesting medication with a self-aggressive intent, ingesting medication with a suicidal intent, and attempting suicide. The respondent is asked to sign the absence or lifetime frequency of each method of self-harm ("No", "Yes – 1 Time", "Yes, 2-10 Times", "Yes, More than 10 Times").

In the current study, we also utilized this instrument to assess parents' awareness about their children deliberate self-harm behaviours. Therefore, parents were asked to sign the absence or lifetime frequency of each method of self-harm for their child.

Questionnaire of Representations About the Functions of Deliberate Self-Harm.

This questionnaire has two versions, one for adolescents (Duarte, Gouveia-Pereira, Gomes & Sampaio, in press-a) and another one for adults (Duarte, Gouveia-Pereira, Gomes & Sampaio, in press-b), which were both used in the current investigation. The questionnaires were validated to Portuguese adolescents and adults and presented acceptable psychometric properties. Both versions of this questionnaire incorporate items from three different sources: the translation of the second section of the Inventory of Statements About Self-Injury (Klonsky & Glenn, 2009), items that resulted from the analysis of interviews and items that emerged from the analysis of Portuguese written press.

These instruments begin with a short introduction mentioning that some young people have deliberate self-harm. In both instruments, the sentence "When young people have these behaviours, they are..." precedes the items. In the questionnaire for adolescents, in order to differentiate between the assessment of the representations from adolescents without deliberate self-harm and the assessment of the motivations/functions of adolescents with a history of these behaviours, it was added a note mentioning that "If you practiced any of these behaviours, please answer according to your experience". The answers are organized on a five point Likert scale: totally disagree, disagree, neither, agree, or totally agree.

The questionnaire for adolescents comprises 35 items that evaluate the representations about 11 functions of deliberate self-harm, which can be categorized according to two dimensions (interpersonal and intrapersonal functions). The interpersonal dimension ($\alpha = .84$, $M = 2.73$, $SD = 0.58$) includes Autonomy & Toughness (e.g. item 24 "Demonstrating they are tough or strong"; $\alpha = .77$, $M = 2.63$, $SD = 0.76$), Interpersonal Boundaries (e.g. item 1 "Creating a boundary between themselves and others"; $\alpha = .83$, $M = 3.16$, $SD = 0.99$),

Interpersonal Influence (e.g. item 7 “Seeking care or help from others”; α = .75, M = 3.02, SD = 0.92), Peer Bonding (e.g. item 11 “Trying to fit in with others”; α = .64, M = 2.47, SD = 0.91) and Revenge (e.g. item 14 “Trying to hurt someone close to them”; α = .67, M = 2.38, SD = 0.85). The intrapersonal dimension (α = .90, M = 3.39, SD = 0.61) includes Affect Regulation (e.g. item 10 “Reducing their anxiety, frustration, anger, or other emotions”; α = . 75, M = 3.73, SD = 0.82), Anti-Dissociation (e.g. item 27 “Inflicting pain in order to feel something”; α = .79, M = 2.96, SD = 0.81), Escape Mechanism (e.g. item 19 “Escaping from problems”; α = .80, M = 3.56, SD = 0.84), Introspective Mechanism (e.g. item 17 “Organizing their ideas”; α = .73, M = 2.58, SD = 0.92), Replacement of Suffering (e.g. item 18 “Creating physical pain to forget the psychological pain”; α = .92, M = 3.72, SD = 0.94) and Self-Punishment (e.g. item 25 “Doing it because they feel guilty”; α = .66, M = 3.64, SD = 0.84).

The questionnaire for adults presents 49 items that assess all the functions aforementioned, as well as three additional intrapersonal functions. Hence, the interpersonal dimension (α = .95, M = 3.00, SD = 0.65) includes Autonomy & Toughness (e.g. item 29 “Demonstrating they are autonomous or independent”; α =.89, M = 2.61, SD = 0.80), Interpersonal Boundaries (e.g. item 22 “Establishing a barrier between themselves and others”; α = .75, M = 2.70, SD = 0.91), Interpersonal Influence (e.g. item 17 “Seeking care or help from others”; α = .81, M = 3.38, SD = 0.78), Peer Bonding (e.g. item 36 “Trying to belong to a group of friends/colleagues”; α = .75, M = 2.57, SD = 0.81) and Revenge (e.g. item 10 “Getting revenge from someone”; α = .72, M = 2.77, SD = 0.92). The intrapersonal dimension (α = .91, M = 2.83, SD = 0.65) includes Affect Regulation (e.g. item 1 “Calming themselves down”; α = .73, M = 2.94, SD = 0.86), Anti-Dissociation (e.g. item 14 “Trying to feel something instead of nothing, even if it is physical pain”; α = .79, M = 2.89, SD = 0.87), Anti-Suicide (e.g. item 15 “Reacting to suicidal thoughts without attempting suicide”; α = .80, M = 2.65, SD = 0.80), Escape Mechanism (e.g. item 43 “Escaping from something that is not right”; α = .76, M = 3.18, SD = 0.83), Introspective Mechanism (e.g. item 34 “Isolating themselves in their thoughts”; α = .81, M = 2.86, SD = 0.77), Marking Distress (e.g. item 19 “Proving themselves that their emotional pain is real”; α = .65, M = 3.11, SD = 0.86), Replacement of Suffering (e.g. item 44 “Physically responding to an emotional pain”; α = .90, M = 3.36, SD = 0.89), Self-Care (e.g. item 23 “Focusing on treating the injury, which can be gratifying or satisfying”; α = .60, M = 2.62, SD = 1.00) and Self-Punishment (e.g. item 13 “Demonstrating the anger they feel for themselves”; α = .87, M = 3.13, SD = 0.78).

Socio-Demographic Questionnaire.

The adolescents responded to questions regarding their age, gender, nationality, education (number of flunks and school grade), the existence of siblings, and marital status of their parents. The socio-demographic questionnaire for parents included items about their age, nationality, education level, marital status and number of children.

Procedures

This research was approved by the General Education Directorate of the Ministry of Education and Science from Portugal regarding the participation of adolescents. Several schools were contacted and informed about the goals of the investigation. After receiving the schools' administration approval, several classes were selected. In a first moment, the researcher delivered the consent forms to the students' parents/legal guardians, along with the parents' questionnaires. The questionnaires for parents were delivered in an envelope, along with a letter informing them that both mother and father should respond separately and give back the questionnaires in the closed envelope to their child, even if they did not complete the questionnaire. In a second moment, the students whose parents/legal guardians signed the consent form completed the questionnaire for adolescents. Also in this second moment, the students brought back their parents' questionnaires and delivered them to the researcher. The participants were informed that their collaboration was voluntary and that all the data was anonymous and confidential. Accordingly, a random code was used to associate the adolescents' questionnaires to their parents' questionnaires.

Data Analysis

All statistical analyses were carried out using SPSS v22 software (IBM SPSS, Chicago, IL). Descriptive statistics were used to analyze socio-demographic data, as well as deliberate self-harm lifetime prevalence. Although both questionnaires that assess the representations about the functions of deliberate self-harm share 11 types of functions, the adults' questionnaire contains three additional functions. Therefore, in order to compare the experiences/representations from these two groups (adolescents and parents), we decided to exclude the functions Anti-Suicide, Marking Distress and Self-Care from the adults' questionnaire. To examine group differences we utilized Repeated Measures ANOVA for paired samples.

Results

In the first set of analyses, we compared the social representations about the functions of deliberate self-harm from adolescents without a history of these behaviours and their parents (Table 1). Results revealed significant differences between the group of adolescents and both groups of parents, and no significant differences between mothers and fathers.

In the interpersonal dimension, adolescents significantly emphasized the function Interpersonal Boundaries (F = 21.60, p = .001), when compared with both parents (mothers and fathers). In addition, both parents significantly emphasized the functions Interpersonal Influence (F = 6.72, p = .01) and Revenge (F = 66.70, p = .01) when compared to the adolescents' group. In the intrapersonal dimension, the group of adolescents significantly emphasized the global intrapersonal dimension (F = 22.85, p = .001) and the functions Affect Regulation (F = 38.41, p = .001), Escape Mechanism (F = 15.01, p = .001), Replacement of Suffering (F = 8.23, p = .001) and Self-Punishment (F = 24.63, p = .001) when compared to both parents. Also, the group of mothers significantly emphasized the function Introspective Mechanism (F = 4.16, p = .05) when compared to adolescents.

Table 1. Families of adolescents without Deliberate Self-Harm (DSH) (N = 456)

	Adolescents Without DSH (n = 152)	Mothers (n = 152)	Fathers (n = 152)	F
Interpersonal Dimension	n.s.	n.s.	n.s.	n.s.
Autonomy & Toughness	n.s.	n.s.	n.s.	n.s.
Interpersonal Boundaries	3.27^{a}	2.68^{b}	2.72^{b}	21.60^{***}
Interpersonal Influence	3.09^{a}	3.39^{b}	3.34^{b}	6.72^{**}
Peer Bonding	n.s.	n.s.	n.s.	n.s.
Revenge	2.46^{a}	2.71^{b}	2.78^{b}	66.70^{**}
Intrapersonal Dimension	3.37^{a}	3.02^{b}	2.97^{b}	22.85^{***}
Affect Regulation	3.62^{a}	2.93^{b}	2.95^{b}	38.41^{***}
Anti-Dissociation	n.s.	n.s.	n.s.	n.s.
Escape Mechanism	3.60^{a}	3.23^{b}	3.17^{b}	15.01^{***}
Introspective Mechanism	2.65^{a}	2.87^{b}	$2.85^{a,b}$	4.16^{*}
Replacement of Suffering	3.66^{a}	3.37^{b}	3.30^{b}	8.23^{***}
Self-Punishment	3.60^{a}	3.15^{b}	3.08^{b}	24.63^{***}

Note. $^{n.s.}$ non-significant; * Significant at .05 level; ** significant at .01 level; *** significant at .001 level. Each superscript letter denotes a subset of each function, different letters represent statistically significant differences between columns.

Globally, these results indicate that most social representations from adolescents and parents were considerably different. However, we did not find significant differences in the global interpersonal dimension and in the functions Autonomy & Toughness, Peer Bonding and Anti-Dissociation, indicating that the three groups had similar social representations concerning this global dimension and these functions. Also, no differences emerged between the representations from mothers and fathers.

In a second moment, we compared the functions represented by adolescents with a history of deliberate self-harm and their parents' social representations about these functions (Table 2). Results revealed differences between adolescents and both groups of parents, as well as between mothers and fathers.

Concerning the interpersonal dimension, results showed that parents (mothers and fathers) significantly emphasized the global interpersonal dimension (F = 11.89, p = .001), and the functions Interpersonal Influence (F = 11.07, p = .001), Peer Bonding (F = 10.98, p = .001) and Revenge (F = 14.14, p = .001) when compared to adolescents. Also, there were marginally significant differences in the function Autonomy & Toughness (F = 2.43, p = .1) which demonstrated that both parents slightly emphasized this function when compared with adolescents.

In the intrapersonal dimension, adolescents significantly emphasized the function Affect Regulation compared with both groups of parents (F = 42.67, p = .001) and the function Escape Mechanism when compared with their fathers (F = 4.59, p = .05). Also, the group of mothers gave significantly more relevance than the group of fathers to Anti-Dissociation (F = 7.52, p = .01). Mothers also significantly emphasized Introspective Mechanism (F = 9.40, p = .001) in comparison with adolescents and fathers. Additionally, adolescents and their mothers significantly emphasized the global intrapersonal dimension (F = 21.72, p = .001), and the intrapersonal functions Replacement of Suffering (F = 17.49, p = . 001) and Self-Punishment (F = 18.63, p = .001).

Table 2. Families of adolescents with deliberate self-harm (DSH) (N = 153)

	Adolescents With DSH (n = 51)	Mothers (n = 51)	Fathers (n = 51)	F
Interpersonal Functions	2.49[a]	3.00[b]	2.80[b]	11.89***
Autonomy & Toughness	2.45[a]	2.73[b]	2.59[b]	2.43†
Interpersonal Boundaries	n.s.	n.s.	n.s.	n.s.
Interpersonal Influence	2.80[a]	3.52[b]	3.29[b]	11.07***
Peer Bonding	2.13[a]	2.85[b]	2.67[b]	10.98***
Revenge	2.14[a]	2.93[b]	2.71[b]	14.14***
Intrapersonal Functions	3.45[a]	3.22[a]	2.84[b]	21.72***
Affect Regulation	4.06[a]	3.09[b]	2.83[b]	42.67***
Anti-Dissociation	2.95[a,b]	3.20[a]	2.66[b]	7.52**
Escape Mechanism	3.44[a]	3.25[a,b]	3.03[b]	4.59*
Introspective Mechanism	2.39[a]	3.03[b]	2.70[a]	9.40***
Replacement of Suffering	3.90[a]	3.72[a]	3.11[b]	17.49***
Self-Punishment	3.76[a]	3.39[a]	2.96[b]	18.63***

Note. n.s. non-significant; † marginally significant at .1 level; * Significant at .05 level; ** significant at .01 level; *** significant at .001 level. Each superscript letter denotes a subset of each function, different letters represent statistically significant differences between columns.

In this group of families, the only function that did not reveal significant differences was Interpersonal Boundaries. These results demonstrate that the social representations from parents were considerably different from the social representations from adolescents, and also that some differences emerged between mothers and fathers.

Discussion

The objective of the present investigation was to analyze and compare the social representations about the functions of deliberate self-harm from adolescents with and without a history of these behaviours and their parents. Hence, we developed two sets of analyses. The first one focused on families (adolescent, mother and father) of adolescents without deliberate self-harm, and the second one centered on families (adolescent, mother and father) of adolescents with deliberate self-harm.

The analyses of the representations about the functions of deliberate self-harm revealed several differences between the groups. Focusing on the families of adolescents without deliberate self-harm, in general, results showed differences between adolescents and both groups of parents. Parents emphasized two interpersonal functions (Interpersonal Influence and Revenge), while adolescents emphasized one interpersonal function (Interpersonal Boundaries) and four intrapersonal functions (Affect Regulation, Escape Mechanism, Replacement of Suffering and Self-Punishment). We hypothesized that there would be no significant differences between adults and adolescents concerning the interpersonal dimension, and that significant differences would emerge in the intrapersonal dimension, where adolescents would emphasize these functions (Hypothesis 1). Most our results confirmed our hypothesis (i.e. adolescents gave more relevance to the intrapersonal dimension than parents). However, mothers and fathers valued Interpersonal Influence and Revenge, which partially contradicts our hypothesis.

Interpersonal Influence refers to the adolescent's attempt to obtain help or manipulate others, while Revenge refers to the adolescent's attempt to take revenge on someone (sometimes due to the emotional pain inflicted by that person). Comparing these functions' nature with the other interpersonal functions, it is possible to conclude that these parents emphasized the two interpersonal functions where the motivations for deliberate self-harm can be directly oriented towards them as parents. Additionally, if we look at these findings taking into account the results obtained in the intrapersonal dimension, it is clear that parents tend to devalue the intrapersonal component of these behaviours (with the exception of the function Introspective Mechanism). These results imply that parents' social representations focus on interpersonal functions that can affect them directly. Regarding these adolescents' results, our findings suggest that their social representations are closer to the adolescents' experiences, mostly because they value intrapersonal functions that are more common among adolescents who self-harm (e.g. Klonsky, 2007).

Our second hypothesis for this set of analyses stated that, if differences did emerge between parents, mothers' social representations would be closer to adolescents' social representations (Hypothesis 2). However, results contradicted this hypothesis, since no differences were found between mothers and fathers.

Regarding families of adolescents with deliberate self-harm, we could verify that the representations' differences seemed to be more accentuated than the ones found in the other group of families. Results revealed that parents emphasized four interpersonal functions

(Autonomy & Toughness, Interpersonal Influence, Peer Bonding and Revenge). On the other hand, these adolescents greatly emphasized Affect Regulation when compared with both their parents and Escape Mechanism when compared with their fathers. We defined two hypothesis for this set of analyses. Firstly, we hypothesized that adolescents with a history of deliberate self-harm would emphasize their experience of intrapersonal functions and, oppositely, parents would value more interpersonal functions than these adolescents (Hypothesis 3). Globally, our results confirmed this hypothesis and are in accordance with previous research that concluded that intrapersonal functions are more prevalent among adolescents with deliberate self-harm (e.g. Klonsky, 2007) and participants without these behaviours tend to value interpersonal functions (Batejan et al., 2015; Duarte, Gouveia-Pereira, Gomes & Sampaio, in press-c).

Comparing the results of these families with the results from families of adolescents without deliberate self-harm, it is possible to verify that there are greater differences between groups. In fact, except for the function Interpersonal Boundaries (which adolescents without deliberate self-harm emphasized significantly more than their parents, while no significant differences were found in families of adolescents with deliberate self-harm), all the differences between means were accentuated. Additionally, taking into account results in both groups of families, our findings indicate that the differences between the groups can be organized according to two main axis: adolescents *versus* adults, and interpersonal functions *versus* intrapersonal functions.

This first axis of differences (adolescents *versus* adults), refers to the fact that most differences in the two types of families appeared between adolescents and both parents (mothers and fathers). Hence, it is clear that parents represent the functions of deliberate self-harm very differently from the social representations of adolescents with and without deliberate self-harm. Also, since these parents do not have personal experiences regarding the functions of these behaviours, our findings indicate that their social representations might be build according to the stereotypes concerning this phenomenon.

However, there were some exceptions to this adults/adolescents axis in our results. In the families of adolescents without behaviours, the function Introspective Mechanism was valued by mothers, devalued by adolescents, and no differences were found regarding parents. In the families of adolescents with behaviours, only one function from the intrapersonal dimension (Affect Regulation) revealed differences between adolescents and both their parents. The other differences were found in the functions Anti-Dissociation, where mothers

emphasized it more than fathers; Escape Mechanism, where adolescents emphasized it more than fathers; and Introspective Mechanism, where mothers emphasized it more than adolescents and fathers. In the two remaining functions (Self-Punishment and Replacement of Suffering), adolescents' experiences and their mothers' social representations were similar.

Our second hypothesis for the group of families with deliberate self-harm stated that, if differences did emerge between mothers and fathers, mothers' social representations would be more similar to the adolescents' social representations (Hypothesis 4). Therefore, these similarities between mothers and adolescents with deliberate self-harm partially confirm our hypothesis. In addition, if we compare the results from the two sets of analyses, Replacement of Suffering and Self-Punishment were the only functions where the mothers' mean was inverted between the two groups (i.e. mothers of adolescents without deliberate self-harm devalued these functions, while mothers of adolescents with deliberate self-harm valued these functions along with their children). Hence, it is accurate to say that mothers' representations of these two functions were closer to the adolescents' representations. We think this similarity may be connected to the fact that mothers usually have closer relationships with their children when compared to fathers (e.g. Collins & Russell, 1991; Doyle et al., 2009; Markiewicz et al., 2006; Tsai et al., 2013). In addition, since of the 51 adolescents with a history of deliberate self-harm in our sample, 38 were female, this result may also relate to the stronger attachment and greater intimacy between mothers and daughters when compared to other parent/child relationships (e.g. Phares, Fields & Kamboukos, 2009; Thompson & Walker, 1984).

The second axis refers to the organization of differences in interpersonal functions *versus* intrapersonal functions. In general, results demonstrated that parents (especially fathers) tend to value interpersonal functions and devalue intrapersonal functions in both types of families. However, in the group of families without deliberate self-harm, this tendency was inverted in the function Interpersonal Boundaries (where adolescents valued this function more than their parents). In this function, deliberate self-harm is a means to assert one's autonomy or to do a distinction between self and others (Klonsky, 2007). Hence, we think this result may be connected to the fact that these adolescents viewed their peers deliberate self-harm as behaviours associated with social isolation, which has been recognized as a risk factor for deliberate self-harm (e.g. Hawton, Fagg & Simkin, 1996; Hawton & James, 2005). In fact, if we compare the means of this function in the two groups of adolescents (without deliberate self-harm, $M = 3.27$; with deliberate self-harm, $M = 2.82$), it is clear that adolescents without these behaviours emphasize Interpersonal Boundaries.

Overall, our research demonstrated that, in both types of families, parents' social representations tend to value interpersonal functions and devalue intrapersonal functions. These findings may suggest that adults still have the stigma and social belief that these behaviours are essentially directed towards others (i.e. a call for attention, or an attempt to obtain revenge) and have a manipulatory nature (Law, Rostill-Brookes and Goodman, 2009), which is a stereotypical perspective. This "attention-seeking argument" (Tantan & Huband, 2009) views deliberate self-harm as behaviours that make illegitimate demands on others, and can negatively affect responses and interventions towards these behaviours. Also, since these parents did not have personal experiences regarding the functions of these behaviours, their representations were build according to these stereotypes concerning this phenomenon. This "gap" between adults' and adolescents' social representations can be an important issue to address during the design of prevention and psychoeducation programs directed to parents.

Focusing on the differences found in the families of adolescents with deliberate self-harm, our results are in accordance with data from other studies. For example, Rissanen and colleagues (2009), recognized the lack of information from parents about this phenomenon, and other studies found that parents of adolescents with self-harm reported difficulties, struggles and uncertainties in understanding and coping with their children behaviours (McDonald et al., 2007; Oldershaw et al., 2008). In fact, the misunderstanding of the functions of deliberate self-harm can have a negative impact during clinical interventions, due to the relevance of parental support (Arbuthnott & Lewis, 2015; Miner, Love & Paik, 2016; Muehlenkamp et al., 2013). In addition, in our sample only eight parents were aware of their children behaviours, which is similar to other studies (Baetens et al., 2015). This particular result underlines the need to create parental awareness regarding deliberate self-harm, in order to allow parents to identify potential self-harm behaviours in their children and encourage help-seeking behaviours.

Finally, previous research has shown that there are differences between the representations about the functions of deliberate self-harm from adolescents without a history of these behaviours and the representations of these functions from adolescents with a history of behaviours (Batejan et al., 2015; Duarte et al., in press-c). Therefore, the results obtained in the present investigation are consistent with the idea that social representations derive from the social belonging and identification of individuals to their social groups (Gouveia-Pereira, Amaral, & Soares, 1997). We conclude that, in this context, the personal experience of deliberate self-harm and the generational differences can be factors that influence the building and modification of these social representations.

Limitations and Directions For Future Research

In summary, our research provided important insight regarding the social representations of the functions of deliberate self-harm from adolescents with and without a history of these behaviours and their parents. However, there are several limitations in this research, including the exclusion of monoparental families, and the fact that we were not able to differentiate between parents who had knowledge of their children self-harm behaviours and those who did not, due to insufficient data.

Since knowing and understanding the representations about the functions of deliberate self-harm can be an important factor for intervention and prevention programs, and taking into account that parents are also relevant elements in these processes, further research is clearly needed in this area. Globally, future research could explore and describe the social representations from adults that can be important for the signaling of deliberate self-harm and posterior intervention, namely from teachers and other school staff. It would also be relevant to compare the social representations of adults with and without a history of deliberate self-harm. In addition, we consider important to compare the social representations between parents that have knowledge of their children deliberate self-harm and those who do not know, to understand how the confront with these behaviours can alter the representations about its functions. Furthermore, it would be interesting to study the relation of these representations (both from adults and adolescents) with other variables, such as psychopathology, suicidal ideation, or religious beliefs.

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Secção III

Discussão Geral

Esta tese de doutoramento teve como principal objectivo a exploração e caracterização das representações sociais sobre as funções dos comportamentos auto-lesivos por parte de adolescentes com e sem estes comportamentos e dos respectivos pais.

Para efectivar este objectivo geral, foram definidos objectivos mais específicos. O primeiro conjunto de objectivos incindiu essencialmente na criação e validação de instrumentos que possibilitassem o estudo destas representações em adolescentes e adultos Portugueses. Esta necessidade surgiu da constatação da escassez de instrumentos validados para Portugal, publicados e cujas qualidades psicométricas tivessem sido testadas. Desta forma, e após o levantamento dos instrumentos existentes para populações internacionais, estipulámos que iríamos adaptar e validar um instrumento que permitisse a avaliação da existência de comportamentos auto-lesivos em adolescentes, e construir e validar dois questionários destinados ao estudo das representações sociais sobre as funções destes comportamentos por parte de adolescentes e adultos. Após esta etapa, o segundo conjunto de objectivos focou-se na exploração e caracterização das representações sociais sobre as funções dos comportamentos auto-lesivos e na sua comparação, abarcando também o estudo da prevalência deste fenómeno.

Assim, a primeira etapa consistiu na adaptação e validação da secção I do *Inventory of Statements About Self-Injury* (Klonsky & Glenn, 2009). Embora existam diversos instrumentos dedicados ao estudo deste fenómeno (e.g. Alexander, 1999; Gratz, 2001; Santa Mina, Gallop & Links, 2006; Whitlock, Exner-Cortens & Purington, 2014), escolhemos este inventário principalmente por apresentar de modo claro e sucinto vários comportamentos auto-lesivos, facilitando a sua utilização nos âmbitos clínico e investigacional. Devido ao facto de alguns estudos apresentarem uma categorização dos comportamentos auto-lesivos de acordo com a sua gravidade (e.g. Croyle & Waltz, 2007; Whitlock et al, 2008), considerámos pertinente analisar a estrutura factorial deste inventário. Uma vez que não foram encontradas análises prévias desta estrutura, levámos a cabo dois estudos nesta validação, a fim de realizar uma análise factorial exploratória e uma análise factorial confirmatória. Para além da tradução do instrumento original, após a consulta de especialistas no estudo de comportamentos auto-lesivos e de uma primeira aplicação do instrumento, foram adicionados e reformulados alguns dos comportamentos enumerados no inventário.

As análises psicométricas efectuadas a este instrumento, denominado Inventário de Comportamentos Auto-Lesivos (ICAL), demonstraram que este é adequado para o estudo da

prevalência e frequência dos comportamentos auto-lesivos, assim como para o conhecimento dos diversos métodos utilizados neste âmbito. A análise factorial exploratória revelou uma estrutura tridimensional (Factor I – Comportamentos Auto-Lesivos Severos e Tentativas de Suicídio; Factor II – Comportamentos Auto-Lesivos Leves/Moderados; Factor III – Consumo de Substâncias Psicoactivas), posteriormente corroborada através da análise factorial confirmatória.

Ao perspectivarmos os comportamentos auto-lesivos como parte de uma linha contínua de gravidade, podemos considerar que o Factor II (Comportamentos Auto-Lesivos Leves/Moderados) se situa no início/meio desse *continuum*, enquanto o Factor I (Comportamentos Auto-Lesivos Severos e Tentativas de Suicídio) se posiciona num ponto mais extremo, abarcando já os actos suicidários. Desta forma, podemos afirmar que os factores apurados nas nossas análises foram consistentes com a literatura existente ao agruparem itens referentes a tipologias semelhantes de métodos, nomeadamente quanto à sua organização consoante a gravidade dos comportamentos (Croyle & Waltz, 2007; Skegg, 2005; Whitlock et al., 2008).

O Factor III (Consumo de Substâncias Psicoactivas), agrupou os itens relativos ao consumo de álcool e outras substâncias psicoactivas. Embora estes comportamentos possam ser considerados típicos da adolescência e socialmente aceites (e.g. Degenhardt et al., 2008; Matos et al., 2012; Zappe & Dell'Aglio, 2016), neste contexto têm subjacente uma intenção auto-agressiva que os distancia dos consumos considerados "normais". Apesar da agregação factorial destes comportamentos fazer sentido, torna-se difícil argumentar onde este factor se posiciona no *continuum* em termos de gravidade. Uma vez que este factor apresentou valores correlacionais positivos com os factores I e II, uma das possibilidades que colocamos é que o consumo de substâncias psicoactivas pode acompanhar a realização de comportamentos auto-lesivos, tal como a literatura tem demonstrado (Haw & Hawton, 2011; Haw, Hawton, Casey, Bale & Shepherd, 2005; McMahon, Reulbach, Corcoran, Keeley, Perry & Arensman, 2010; Rossow et al., 2007; Rossow, Hawton, & Ystgaard, 2009; Rossow & Norström, 2014). Por outro lado, tendo em conta que este é um factor distinto, questionamos se estes consumos podem também funcionar como uma "porta de entrada" para comportamentos auto-lesivos considerados mais graves, ao assumirem um cariz auto-agressivo.

O conhecimento desta estrutura factorial pode ser um elemento importante no âmbito clínico, em particular porque se sabe que comportamentos mais severos estão associados a psicopatologias e a um maior risco de suicídio (Whitlock et al., 2008). Por acréscimo, a

categorização e o conhecimento das diversas tipologias destes comportamentos podem contribuir para a adequação dos tratamentos clínicos e das abordagens psicoterapêuticas (Whitlock et al., 2008), bem como para a sensibilização quanto à existência de um *continuum* auto-lesivo em que comportamentos menos graves poderão levar à prática de comportamentos mais severos.

Em termos gerais, consideramos que cumprimos os objectivos quanto à adaptação e validação do ICAL. Para além de ser um instrumento breve e claro, que demonstrou qualidades psicométricas aceitáveis, este inventário apresenta diversos métodos auto-lesivos, categoriza a sua frequência e permite o agrupamento factorial de diversos comportamentos de acordo com o nível de gravidade. Assim, o ICAL é uma ferramenta passível de ser utilizada nos contextos clínico e investigacional, e que pode promover o aprofundamento do conhecimento sobre a prática destes comportamentos.

Após a validação de um instrumento que nos permitisse avaliar a existência de comportamentos auto-lesivos, a etapa que se seguiu consistiu na validação de instrumentos destinados ao estudo das representações sociais sobre as funções destes comportamentos por parte de adolescentes e adultos sem uma história dos mesmos. No entanto, por não termos encontrado nenhum instrumento desenvolvido especificamente com este intuito, incluindo a literatura internacional, optámos pelo desenvolvimento de dois questionários. Uma vez que a segunda secção do *Inventory of Statements About Self-Injury* (Klonsky & Glenn, 2009) já foi utilizada anteriormente para o estudo das percepções de estudantes sem estes comportamentos (Batejan et al., 2015) e caracteriza 13 tipos de funções dos comportamentos auto-lesivos, optámos pela utilização desta escala como base para a construção dos questionários destinados aos estudo das representações sociais. Contudo, este instrumento foi concebido para ser respondido por adolescentes com uma história de comportamentos auto-lesivos e os seus itens foram delineados a partir de uma revisão da literatura, da discussão com investigadores com conhecimentos sobre o tema e da análise do conteúdo de *websites* criados por e para adolescentes com estes comportamentos. Desta forma, considerámos necessário complementar as funções e os itens do *Inventory of Statements About Self-Injury* com conteúdos ligados às representações sociais sobre as funções dos comportamentos auto-lesivos de adolescentes com e sem estes comportamentos e adultos. Para tal, realizámos diversas entrevistas semi-directivas e analisámos uma amostra da imprensa generalista escrita Portuguesa.

O segundo artigo apresentado consistiu, então, na análise qualitativa das entrevistas realizadas a fim de complementar os itens/funções do instrumento mencionado. Para além deste objectivo, esta etapa contemplou também a caracterização das representações sobre as funções dos comportamentos auto-lesivos de adolescentes com e sem estes comportamentos e de adultos igualmente sem estes comportamentos, e na comparação das representações entre estes três grupos.

Da análise de conteúdo das 41 entrevistas emergiram 10 funções passíveis de serem agrupadas de acordo com o seu cariz interpessoal ou intrapessoal (Klonsky, Glenn, Styer, Olino & Washburn, 2015). As funções interpessoais incluíram a Influência Interpessoal, Fronteiras Interpessoais, Ligação com os Pares e Tentativa de Comunicação. As funções intrapessoais englobaram a Anti-Dissociação, Auto-Punição, Auto-Regulação do Afecto, Mecanismo de Fuga, Mecanismo Introspectivo e Substituição do Sofrimento. Destas 10 funções, duas não foram encontradas na literatura (Mecanismo Introspectivo e Substituição do Sofrimento). Comparando as funções apuradas com as funções propostas por Klonsky e Glenn (2009), os entrevistados referiram apenas seis das 13 mencionadas pelos autores. Focando os conteúdos representacionais dos três grupos, surgiram algumas diferenças. Em termos gerais, o grupo de adolescentes com uma história de comportamentos auto-lesivos apresentou representações sociais mais ligadas às funções intrapessoais, particularmente a função Auto-Regulação do Afecto. O grupo de adultos fez mais referências às funções interpessoais, e o grupo de adolescentes sem comportamentos auto-lesivos situou-se num "ponto intermédio" em que apresentou representações sociais que se aproximavam das dos adolescentes com comportamentos. Estes resultados foram ao encontro dos poucos estudos realizados até à data que compararam as perspectivas de sujeitos com e sem comportamentos auto-lesivos (Batejan et al., 2015), em específico devido ao facto dos participantes sem comportamentos auto-lesivos valorizarem as funções interpessoais. No entanto, um olhar mais próximo dos conteúdos das entrevistas revelou outras diferenças interessantes, que foram detalhadas no respectivo artigo.

A partir da análise das entrevistas emergiram diversos itens que complementaram funções já descritas no *Inventory of Statements About Self-Injury* e também quatro novas funções não incluídas neste instrumento – Mecanismo de Fuga; Mecanismo Introspectivo; Substituição do Sofrimento; e Tentativa de Comunicação. Conjuntamente com a análise das entrevistas, a análise de conteúdo sobre este fenómeno de uma amostra de vários jornais e revistas Portugueses permitiu-nos acrescentar mais itens a ambos os questionários das representações.

Após estes passos, obtivemos as primeiras versões dos Questionários sobre as Funções dos Comportamentos Auto-Lesivos (QRFCAL) para adolescentes e adultos. Seguiram-se as validações de ambos os instrumentos, que não descreveremos em pormenor por já terem sido detalhadas no terceiro e quarto artigos. Os objectivos para estas validações consistiram na avaliação das qualidades psicométricas dos instrumentos, englobando a análise da validade factorial quanto às diversas funções e às dimensões intrapessoal e interpessoal.

A validação do QRFCAL-Adolescentes (artigo 3) incluiu dois estudos, o primeiro para a análise factorial exploratória e redução de itens, e o segundo para a análise factorial confirmatória. A primeira versão do instrumento incluia 75 itens que correspondiam a 17 funções (13 funções advindas do *Inventory of Statements About Self-Injury* e quatro funções que emergiram da análise de entrevistas e da análise da imprensa escrita Portuguesa). No estudo 1 foram realizadas diversas análises factoriais exploratórias das duas grandes dimensões (interpessoal e intrapessoal) e das 17 funções. Os resultados destas análises permitiram reduzir os itens do questionário, sendo que a versão final do instrumento continha 35 itens (20 deles novos itens) e 11 funções. Destas 11 funções, três consistiram em novas funções advindas das análises das entrevistas e da imprensa escrita – Mecanismo de Fuga, Mecanismo Introspectivo e Substituição do Sofrimento – que se agruparam na dimensão intrapessoal. Durante este processo de redução de itens, as funções Anti-Suicídio, Auto-Cuidado, Procura de Sensações, Simbolização do Sofrimento e Tentativa de Comunicação foram excluídas do questionário.

O estudo 2 baseou-se numa análise factorial confirmatória direccionada para a avaliação da estrutura do QRFCAL-Adolescentes quanto às duas dimensões (interpessoal e intrapessoal) e em termos das 11 funções. Os resultados obtidos neste momento revelaram uma estrutura de dois factores estável, indo ao encontro de investigações prévias (Bildik, Somer, Kabukçu-Başay, Başay & Özbaran, 2013; Klonsky et al., 2015; Kortge et al., 2013; Lindholm, Bjärehed & Lundh, 2011). Por conseguinte, os resultados revelaram igualmente uma organização factorial satisfatória em termos das cinco funções interpessoais e das seis funções intrapessoais.

Em termos gerais, estes resultados indicam que o QRFCAL-Adolescentes apresenta qualidades psicométricas aceitáveis, confirmando-se a sua validade factorial. Existem algumas limitações inerentes aos estudos que constam no artigo 3, nomeadamente o facto da amostra ser de conveniência e não termos analisado a validade convergente e divergente. Não obstante, os resultados obtidos permitem-nos concluir que este é um instrumento adequado

para o estudo das representações sociais de adolescentes sobre as funções dos comportamentos auto-lesivos.

A etapa seguinte consistiu na validação do QRFCAL-Adultos (artigo 4), que englobou também dois estudos: o primeiro baseou-se na análise factorial exploratória e na redução de itens, e o segundo focou-se na análise factorial confirmatória da estrutura obtida. A primeira versão do instrumento incluía 75 itens que remetiam para 17 funções (13 funções que emergiram do *Inventory of Statements About Self-Injury* e quatro funções que surgiram com base na análise de entrevistas e na análise da imprensa escrita Portuguesa). Tal como no artigo anterior, no estudo 1 foram realizadas análises factoriais exploratórias quanto às duas grandes dimensões (interpessoal e intrapessoal) e às 17 funções independentes. Os resultados obtidos contribuíram primeiramente para a redução de itens, sendo que a segunda versão do mesmo continha 49 itens (19 deles novos itens) e 14 funções. Tal como na validação do QRFCAL-Adolescentes, destas 14 funções, três consistiram em novas funções advindas das análises das entrevistas e da imprensa escrita, que se agruparam na dimensão intrapessoal – Mecanismo de Fuga, Mecanismo Introspectivo e Substituição do Sofrimento. O processo de redução de itens levou à eliminação das funções Procura de Sensações e Tentativa de Comunicação.

À semelhança do artigo anterior, o estudo 2 desta validação baseou-se numa análise factorial confirmatória destinada a avaliar a estrutura do QRFCAL-Adultos em termos das duas dimensões (interpessoal e intrapessoal) e das 14 funções. Os resultados obtidos com esta análise demonstraram uma estrutura de dois factores estável, indo ao encontro de outras investigações (Bildik et al., 2013; Klonsky et al., 2015; Kortge et al., 2013; Lindholm, et al., 2011), e uma organização factorial satisfatória em termos das cinco funções interpessoais e das nove funções intrapessoais.

Através deste processo foi-nos possível verificar que o QRFCAL-Adultos apresenta qualidades psicométricas aceitáveis, confirmando-se a sua validade factorial. Assim, apesar de existirem algumas limitações inerentes a esta validação (amostra de conveniência e ausência de análise da validade convergente e divergente), os resultados obtidos demonstram que este instrumento é adequado para o estudo das representações sociais de adultos sobre as funções dos comportamentos auto-lesivos.

Observando os resultados de ambas as validações destes questionários (QRFCAL-Adolescentes e QRFCAL-Adultos), é possível verificar que após o processo de redução de itens, o questionário para adultos manteve mais funções do que o questionário dirigido a adolescentes. Tendo em conta que as primeiras versões de ambos os questionários

apresentavam o mesmo número de itens e de funções, este resultado leva-nos a crer que os adultos associam mais conteúdos às representações sociais sobre as funções Anti-Suicídio, Auto-Cuidado e Simbolização do Sofrimento, que se mantiveram no QRFCAL-Adultos.

Após a adaptação e validação do ICAL e a construção e validação do QRFCAL-Adolescentes e do QRFCAL-Adultos, avançámos para a seguinte etapa investigacional. Esta consistiu no segundo conjunto de objectivos da presente tese, incidindo na caracterização das representações sociais sobre as funções dos comportamentos auto-lesivos por parte de adolescentes com e sem estes comportamentos e de adultos. Assim, os estudos empíricos que contribuíram directamente para o estudo destas representações foram apresentados no quinto e sexto artigo que compõem esta tese. O artigo 5 englobou dois estudos e o artigo 6 baseou-se em dois conjuntos de análises, que seguidamente resumimos.

Num primeiro momento, focámo-nos na comparação das representações sociais sobre as funções dos comportamentos auto-lesivos de adolescentes com e sem estes comportamentos (estudo 1 do artigo 5). Neste âmbito, as escassas investigações realizadas até à data revelaram que os adolescentes sem comportamentos auto-lesivos atribuem mais importância a funções de cariz interpessoal (Batejan et al., 2015). Por acréscimo, as funções intrapessoais são comummente mais enfatizadas por adolescentes com comportamentos auto-lesivos (Klonsky, 2007b). Assim, a hipótese que colocámos para este estudo foi que os adolescentes com uma história de comportamentos auto-lesivos iriam apresentar representações sociais que incidiriam na valorização significativa da sua experiência das funções intrapessoais e que, pelo contrário, os adolescentes sem uma história destes comportamentos iriam revelar representações sociais com mais ênfase nas funções interpessoais.

Tal como previsto, os resultados obtidos revelaram que os adolescentes sem estes comportamentos valorizaram todas as funções interpessoais. Os adolescentes com uma história de comportamentos destacaram marginalmente a função Substituição do Sofrimento, e valorizaram significativamente a função Auto-Regulação do Afecto. Em termos globais, estes resultados confirmaram a nossa hipótese, especialmente pelo facto dos adolescentes sem comportamentos auto-lesivos terem salientado a dimensão interpessoal, indo ao encontro de outros estudos (Batejan et al., 2015; Bresin et al., 2013). No entanto, as grandes diferenças na dimensão intrapessoal verificaram-se somente na função Auto-Regulação do Afecto, sendo claro que esta foi a função mais experienciada pelos adolescentes com comportamentos, tal como sugere a literatura (Klonsky, 2007b). Assim, a experiência pessoal dos comportamentos

auto-lesivos influencia o tipo de representações sociais que os adolescentes controem quanto aos mesmos.

Globalmente, é possível concluir que as representações sociais dos adolescentes sem comportamentos quanto à dimensão interpessoal se aproximam da ideia estereotipada de que estes comportamentos são direccionados para outros indivíduos e que possuem uma natureza manipulatória (Law, Rostill-Brookes & Goodman, 2009). No referente à dimensão intrapessoal, os resultados sugerem que as representações sociais dos adolescentes sem comportamentos auto-lesivos se aproximam das experiências mencionadas pelos adolescentes com uma história destes comportamentos. Porém, a discrepância encontrada na função Auto-Regulação do Afecto aponta para a incompreensão da importância da mesma por parte dos adolescentes sem comportamentos.

Num segundo momento, focámo-nos na comparação das representações sociais sobre as funções dos comportamentos auto-lesivos de mães e pais de adolescentes com e sem estes comportamentos (estudo 2 do artigo 5). Embora a literatura tenha demonstrado que os pais não apresentam uma compreensão clara dos comportamentos auto-lesivos e respectivas implicações (McDonald et al., 2007; Oldershaw et al., 2008), colocámos a hipótese de que iriam surgir diferenças entre os grupos de pais (mães e pais) de adolescentes com e sem estes comportamentos.

Os resultados não demonstraram quaisquer diferenças na dimensão interpessoal, o que implica que os quatro grupos de pais representam estas funções de forma semelhante. Na dimensão intrapessoal, surgiram diferenças entre vários grupos nas funções Anti-Dissociação, Anti-Suicídio, Auto-Punição, Mecanismo Introspectivo, Simbolização do Sofrimento e Substituição do Sofrimento. Em termos das diferenças grupais, foi possível constatar que todas as diferenças surgiram entre mães e pais, principalmente entre as mães de adolescentes com comportamentos auto-lesivos e ambos os grupos de pais. Assim, consideramos que os resultados confirmaram parcialmente a nossa hipótese, embora esperássemos divergências entre os grupos de pais (mães e pais) de adolescentes com e sem comportamentos e as diferenças tenham surgido entre os grupos de mães e de pais.

O facto de não terem surgido diferenças entre os grupos na dimensão interpessoal revela que a presença de um adolescente com comportamentos auto-lesivos numa família não implica diferentes representações sociais por parte dos pais. Contudo, não nos foi possível explorar as diferenças entre pais com e sem conhecimento dos comportamentos auto-lesivos por parte dos seus filhos, uma vez que na nossa amostra apenas 12 pais tinham este

conhecimento. Quanto à dimensão intrapessoal, tendo em conta que as mães valorizaram várias funções intrapessoais e que estas funções são mais referenciadas por adolescentes com comportamentos auto-lesivos (Klonsky, 2007b), consideramos que estes resultados podem estar ligados à maior proximidade existente entre mães e filho(a)s (Collins & Russell, 1991; Doyle, Lawford & Markiewicz, 2009; Markiewicz, Lawford, Doyle & Haggart, 2006; Tsai, Telzer, & Fuligni, 2013). Deste modo, concluímos com este estudo que a simples presença de comportamentos auto-lesivos por parte dos filhos não se associa a diferentes representações sociais por parte dos pais, e que o género e a proximidade relacional com o adolescente poderão ser factores mais relevantes para a construção destas representações.

Após estes estudos, considerámos importante analisar e comparar as representações sociais em famílias (adolescentes e respectivos mães e pais) de adolescentes com e sem estes comportamentos (artigo 6). Este artigo envolveu, assim, dois conjuntos de análises, o primeiro abarcando somente famílias de adolescentes sem comportamentos auto-lesivos, o segundo englobando famílias de adolescentes com comportamentos auto-lesivos.

Tal como mencionado anteriormente, estudos prévios destacaram o desconhecimento parental das motivações e funções destes comportamentos (McDonald et al., 2007; Oldershaw et al., 2008) e concluíram que jovens sem estes comportamentos valorizam algumas funções interpessoais mais do que jovens sem comportamentos (Batejan et al., 2015). Por acréscimo, a literatura sugere uma maior proximidade entre mães e filhos (Collins & Russell, 1991; Doyle et al., 2009; Markiewicz et al., 2006; Tsai et al., 2013). Deste modo, para o primeiro conjunto de análises colocámos duas hipóteses: a) que não existiriam diferenças significativas entre os pais e os adolescentes na dimensão interpessoal e que surgiriam algumas diferenças significativas na dimensão intrapessoal, em que os adolescentes iriam valorizar estas funções; b) que, no caso de surgirem diferenças entre os grupos de pais, as representações sociais das mães se iriam aproximar das representações sociais dos adolescentes.

Assim, no que diz respeito às famílias de adolescentes sem comportamentos, os resultados obtidos demonstraram que, na dimensão interpessoal, os pais enfatizaram as funções Influência Interpessoal e Vingança, e os adolescentes enfatizaram a função Fronteiras Interpessoais. Na dimensão intrapessoal, o grupo de adolescentes valorizou quatro funções mais do que ambos os grupos de pais. Assim, estes resultados confirmaram parcialmente a nossa primeira hipótese, embora tenham surgido ligeiras diferenças na dimensão interpessoal. No que se refere à segunda hipótese que postulámos, não foram encontradas diferenças significativas entre ambos os grupos de pais.

Seguiu-se o segundo conjunto de análises, que focou somente famílias de adolescentes com comportamentos auto-lesivos. De acordo com a já referida maior frequência de funções intrapessoais em adolescentes com comportamentos auto-lesivos (Klonsky, 2007b) e com a também já mencionada maior proximidade relacional entre mães e filhos (Collins & Russell, 1991; Doyle et al., 2009; Markiewicz et al., 2006; Tsai et al., 2013), estipulámos igualmente duas hipóteses para estas famílias: a) que os adolescentes iriam valorizar as funções intrapessoais, enquanto os pais iriam enfatizar as funções interpessoais; b) que, se surgissem diferenças entre pais e mães, as representações sociais das mães se iriam aproximar das representações sociais dos filhos.

Os resultados obtidos demonstraram que, na dimensão interpessoal, os pais valorizaram quatro das cinco funções (Autonomia & Resistência, Influência Interpessoal, Ligação com os Pares e Vingança), confirmando a nossa primeira hipótese. Na dimensão intrapessoal, os resultados confirmaram parcialmente a hipótese definida, uma vez que surgiu apenas uma diferença entre os adolescentes e ambos os grupos de pais (Auto-Regulação do Afecto), e as restantes diferenças verificaram-se entre os adolescentes/mães e os pais (Auto-Punição e Substituição do Sofrimento), os adolescentes e os pais (Mecanismo de Fuga), as mães e os pais (Anti-Dissociação), e os adolescentes/pais e as mães (Meio Introspectivo).

Globalmente, consideramos que os estudos realizados nestes dois últimos artigos nos permitiram alcançar os objectivos que havíamos traçado para este momento investigacional, contribuindo para a caracterização das representações sociais sobre as funções dos comportamentos auto-lesivos por parte de adolescentes com e sem comportamentos auto-lesivos e por parte de pais de adolescentes com e sem estes comportamentos. Assim, partindo da observação conjunta dos resultados do artigo 2 (entrevistas), artigo 5 e artigo 6, existem algumas conclusões que devemos salientar.

Em primeiro lugar, os estudos que realizámos demonstraram que existem diferenças entre as representações sociais de adolescentes com e sem comportamentos auto-lesivos e entre estes adolescentes e os respectivos pais. Por conseguinte, os nossos resultados revelaram que estas diferenças se observam particularmente no eixo interpessoal/intrapessoal onde as diversas funções dos comportamentos auto-lesivos podem ser organizadas (Klonsky et al., 2015; Kortge et al., 2013; Nock & Prinstein, 2004).

Começaremos por analisar a dimensão interpessoal, onde se agrupam as funções de cariz social e/ou dirigidas ao outro (i.e. Ligação com os Pares ou Vingança). Os nossos resultados demonstraram que nos indíviduos sem comportamentos auto-lesivos emergiram

representações sociais que valorizam estas funções, especialmente por parte dos pais e mães. Embora os adolescentes sem comportamentos auto-lesivos tenham destacado consideravelmente as funções interpessoais ao serem comparados com adolescentes com estes comportamentos (artigo 2 e estudo 1 do artigo 5), quando esta comparação ocorreu entre adolescentes sem comportamentos e os respectivos pais, estas diferenças esbateram-se (artigo 6). Por oposição, os adolescentes com uma história de comportamentos auto-lesivos desvalorizaram sempre estas funções comparativamente com outros adolescentes e com os seus pais (estudo 1 do artigo 5 e artigo 6).

Tendo em conta estes resultados, a nossa hipótese explicativa para os mesmos parte da ideia de que as representações sociais de indivíduos sem estes comportamentos se baseiam na perspectiva estereotipada de que os comportamentos auto-lesivos têm uma natureza manipulatória (Law et al., 2009), e que visam a influência sobre outrém ou o despoletar de determinadas reacções (Tantan & Huband, 2009). No entanto, e apesar de existirem funções interpessoais reportadas por adolescentes com estes comportamentos (Muehlenkamp et al., 2013), estas representações sociais afastam-se das motivações interpessoais reportadas pelos mesmos, usualmente assentes na utilização dos comportamentos auto-lesivos como um pedido de ajuda, tal como os conteúdos das nossas entrevistas demonstraram.

Analisamos de seguida a dimensão intrapessoal, onde se aglomeram as funções automáticas, reforçadas pelo próprio sujeito que realiza estes comportamentos (i.e. Auto-Punição ou Auto-Regulação do Afecto). Os resultados que obtivemos revelaram que os adolescentes com comportamentos auto-lesivos enfatizaram tendencialmente as representações sociais que incidem nestas funções. Porém, existem poucas diferenças nesta dimensão quando as representações sociais de adolescentes com comportamentos auto-lesivos são comparadas com as representações sociais de adolescentes sem comportamentos (artigo 2 e estudo 1 do artigo 5), excepto na função Auto-Regulação do Afecto, que os adolescentes com comportamentos destacaram continuamente. Quando focámos esta dimensão ao nível familiar (artigo 6), os adolescentes sem comportamentos enfatizaram as funções intrapessoais mais do que ambos os grupos de pais. Porém, nas famílias de adolescentes com comportamentos auto-lesivos, as representações sociais dos adolescentes aproximaram-se das representações das mães e ambas contrastaram com as representações dos pais, que desvalorizaram globalmente estas funções.

Consideramos que estes resultados podem ser enquadrados com base em duas hipóteses explicativas. Primeiramente, e de acordo com o previamente mencionado, a

aproximação das representações sociais das mães das experiências dos adolescentes poderá estar relacionada com a maior proximidade entre estes elementos familiares (Collins & Russell, 1991; Doyle et al., 2009; Markiewicz et al., 2006; Tsai et al., 2013). Em segundo lugar, no que se refere às semelhanças entre as representações sociais de adolescentes com e sem comportamentos auto-lesivos, é possível que a comunicação entre estes adolescentes seja um factor importante. Assim, consideramos que os adolescentes com comportamentos partilharão a sua experiência quanto às funções intrapessoais com amigos próximos, o que poderá contribuir para a modificação das suas representações sociais e para esta similaridade em termos da dimensão intrapessoal.

De uma perspectiva geral, estes resultados demonstraram que as grandes assimetrias entre os grupos se concentraram na dimensão interpessoal e que, na dimensão intrapessoal, as representações sociais de adolescentes sem comportamentos auto-lesivos e das mães de adolescentes com comportamentos auto-lesivos se aproximaram das experiências dos mesmos por parte de adolescentes com estes comportamentos. São diversas as possíveis implicações destes resultados, que foram sendo enumeradas ao longo dos artigos que compõem esta tese. Não obstante, destacamos a relevância que estes resultados podem ter no âmbito clínico, nomeadamente por: a) terem contribuído para a identificação das funções mais reportadas por adolescentes com comportamentos auto-lesivos; b) terem permitido o reconhecimento de que as mães poderão ser elementos relevantes em contextos clínicos e psicoterapêuticos por terem representações sociais mais semelhantes às experiências intrapessoais dos adolescentes; c) terem revelado que os pais deverão ser um um foco de psicoeducação devido ao afastamento das suas representações sociais das experiências dos adolescentes; d) terem reconhecido a similaridade entre as representações sociais do grupo de pares e as experiências auto-lesivas intrapessoais. Assim, e uma vez que a literatura sublinha a importância do papel dos pais (e.g. Arbuthnott & Lewis, 2015; Muehlenkamp et al., 2013; Santos, 2007; Sutton, 2007) e do grupo de pares (e.g. Evans et al., 2005; Hasking et al., 2015; Heath et al., 2009) em contextos clínicos e de intervenção, consideramos que os resultados obtidos poderão simultaneamente contribuir para o delineamento de abordagens nestes âmbitos e para a estruturação de programas de prevenção.

Direcções Futuras e Considerações Finais

Consideramos que os artigos que compõem esta tese apresentam contributos importantes, embora preliminares, no âmbito do estudo das representações sociais sobre as

funções dos comportamentos auto-lesivos. Assim, é clara a necessidade da realização de mais estudos que permitam não só ultrapassar algumas das limitações mencionadas nos diversos artigos, como também contribuir para uma compreensão mais profunda destas representações.

No que se refere aos três instrumentos validados, embora os estudos realizados tenham demonstrado qualidades psicométricas aceitáveis, consideramos necessária a continuação do estudo das mesmas, incluindo a averiguação da sua validade convergente e divergente, bem como a confirmação da estabilidade das estruturas factoriais apuradas e a exploração da sua estabilidade temporal.

Em termos dos nossos estudos empíricos, primeiramente seria pertinente a replicação dos resultados obtidos. Posteriormente, o estudo das representações sociais sobre as funções dos comportamentos auto-lesivos conjuntamente com outras variáveis poderia contribuir para a compreensão das mesmas. Por acréscimo, uma vez que o QRFCAL-Adolescentes nos permite igualmente aceder às funções que motivam a prática de comportamentos auto-lesivos, o estudo da relação destas funções com outras variáveis permitiria o aprofundamento da literatura sobre este fenómeno. Destacamos, a título de exemplo, algumas variáveis que se encontram relacionadas com a prática de comportamentos auto-lesivos e que poderiam ser estudadas neste âmbito, como a impulsividade (Glenn & Klonsky, 2010; Lockwood et al., 2017; Madge et al., 2011), baixa auto-estima (Hawton et al., 2002; Laye-Gindhu & Schonert-Reichl, 2005; Lundh et al., 2007), comportamentos anti-sociais (Ayton et al., 2003; Jacobson & Gould, 2007), distúrbios alimentares (Jeppson et al., 2003; Mahadevan et al., 2010; Ross et al., 2009; Taliaferro & Muehlenkamp, 2015), ansiedade (Brunner et al., 2013; Chartrand et al., 2012), depressão (Boone & Brausch, 2016; Brunner et al., 2013; Carneiro et al., 2017; Santos et al., 2009; Serras et al., 2010; Taliaferro & Muehlenkamp, 2015), perturbação de personalidade *borderline* (Baker et al., 2008; Ferrara et al., 2012; Vega et al., 2017), entre muitas outras.

Focando o estudo destas representações em famílias, seria primeiramente importante comparar as representações sociais de pais que têm conhecimento dos comportamentos auto-lesivos dos filhos com as representações sociais de pais sem este conhecimento, a fim de perceber de que forma esta tomada de conhecimento altera as representações já existentes. Seria igualmente pertinente conjugar o estudo destas representações em famílias com estruturas diferentes (i.e. famílias monoparentais), com *backgrounds* culturais distintos, ou com influências religiosas diversas. Existem também factores familiares que têm sido associados à prática de comportamentos auto-lesivos por parte dos adolescentes e que

poderiam ser enquadrados com estas representações sociais, nomeadamente a existência de uma história familiar de comportamentos suicidários (Brent & Mann, 2005; Deliberto & Nock, 2008; Hawton et al., 2002; Jobes & Schneidman, 2006), eventos de vida negativos ou stressantes (Madge et al., 2011), alcoolismo na família (Hawton & James, 2005), ou problemas relacionais com os pais (Di Pierro, Sarno, Perego, Gallucci & Madeddu, 2012). Por acréscimo, estudos longitudinais que se focassem nas possíveis modificações das representações sociais das famílias de adolescentes com comportamentos auto-lesivos ao longo de intervenções clínicas poderiam também ser um foco investigacional relevante.

Para além da esfera familiar, e no seguimento da literatura existente, seria interessante dar seguimento à exploração das representações sociais de técnicos de saúde, professores e outros indivíduos que desempenhem um papel importante na sinalização e na intervenção perante comportamentos auto-lesivos (Berger et al., 2014; Karman et al., 2015; McHale & Felton, 2010), particularmente em Portugal.

A propósito desta necessidade de identificar adolescentes com comportamentos auto-lesivos e de traçar planos de intervenção, resta-nos sublinhar que os nossos resultados revelaram o desconhecimento geral dos pais quanto à prática destes comportamentos por parte dos seus filhos. Assim, consideramos premente a criação de planos de prevenção e psicoeducação que se foquem nos pais e valorizem o seu papel neste âmbito.

Num tom conclusivo, consideramos que os artigos que compõem esta tese apresentam dois contributos distintos, mas que se complementam. O primeiro parte das três validações realizadas, que possibilitam a utilização de vários instrumentos em futuras investigações e em contextos clínicos. O segundo contributo advém dos resultados dos estudos empíricos e consiste no reconhecimento das diferenças existentes entre as representações sociais sobre as funções dos comportamentos auto-lesivos. Esperamos, assim, que esta tese tenha contribuido para uma melhor compreensão do fenómeno dos comportamentos auto-lesivos e dos diversos dialectos da dor em que estes se revelam.

"No matter how hard you try,

nothing else will speak like that cut or that burn or that bruise.

No amount of poetry or painting can say

what you want to say when you cut."

(Underman, 2005)

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Secção IV

Anexos

Anexo A: Materiais e Medidas de *Adaptação e Validação do Inventário de Comportamentos Auto-Lesivos para Adolescentes*

Inventory of Statements About Self-Injury (Instrumento Original)

INVENTORY OF STATEMENTS ABOUT SELF-INJURY (ISAS) – SECTION I. **BEHAVIORS**

This questionnaire asks about a variety of self-harm behaviors. Please only endorse a behavior if you have done it intentionally (i.e., on purpose) and without suicidal intent (i.e., not for suicidal reasons).

---

1. Please estimate the number of times in your life you have intentionally (i.e., on purpose) performed each type of non-suicidal self-harm (e.g., 0, 10, 100, 500):

Cutting ____	Severe Scratching ____
Biting ____	Banging or Hitting Self ____
Burning ____	Interfering w/ Wound Healing (e.g., picking scabs) ____
Carving ____	Rubbing Skin Against Rough Surface ____
Pinching ____	Sticking Self w/ Needles ____
Pulling Hair ____	Swallowing Dangerous Substances ____
Other _____, ____	

****

***Important*: If you have performed one or more of the behaviors listed above, please complete the final part of this questionnaire. If you have not performed any of the behaviors listed above, you are done with this particular questionnaire and should continue to the next.**

****

---

2. If you feel that you have a *main* form of self-harm, please circle the behavior(s) on the first page above that you consider to be your main form of self-harm.

---

3. At what age did you:

First harm yourself? _____ Most recently harm yourself? _____

(approximate date – month/date/year)

4. Do you experience physical pain during self-harm?

Please circle a choice: YES SOMETIMES NO

5. When you self-harm, are you alone?

Please circle a choice: YES SOMETIMES NO

6. Typically, how much time elapses from the time you have the urge to self-harm until you act on the urge?

Please circle a choice:

< 1 hour 1 - 3 hours 3 - 6 hours

6 - 12 hours 12 - 24 hours > 1 day

7. Do/did you want to stop self-harming?

Please circle a choice: YES NO

Inventário de Comportamentos Auto-Lesivos (Versão Adaptada Final)

ICAL

1. Por favor, assinala se ao longo da tua vida já realizaste **intencionalmente** (ou seja, de tua própria vontade) cada um destes comportamentos **em ti próprio e com a ideia de fazeres mal a ti mesmo**:

	NÃO	**SIM**		
		1 vez	2 a 10 vezes	mais de 10 vezes
Cortei-me				
Mordi-me				
Queimei-me				
Puxei/Arranquei o cabelo				
Cocei/Arranhei-me até fazer uma ferida (sem ser por causa de comichão)				
Consumi drogas com a intenção de me magoar				
Espetei-me com agulhas				
Engoli substâncias perigosas com a intenção de me magoar				
Bebi em excesso com a intenção de me magoar				
Bati com o corpo ou bati em mim próprio				
Ingeri em demasia um medicamento com a intenção de me magoar				
Ingeri em demasia um medicamento com a intenção de morrer				
Tentei suicidar-me				
Outros. Quais? _____				

2. Por favor descreve, **com o máximo de detalhes possíveis**, a vez que mais te marcou em que fizeste um destes comportamentos:

_____

_____

_____

3. Com que idade realizaste estes comportamentos pela primeira vez? _____

4. Quando realizaste estes comportamentos pela última vez? ____ / _____ / _____
(Data aproximada dia/mês/ano)

5. De onde retiraste a ideia para fazer estes comportamentos? Por favor, assinala uma ou mais opções:

☐ Internet (Facebook, Tumblr, sites, etc) ☐ Livros

☐ Filmes/Séries ☐ Amigos/Colegas

☐ Outro Sítio. Qual? _____

6. Sentes dor física quando realizas estes comportamentos? Por favor, assinala uma das opções:

Nunca	Raramente	Algumas Vezes	Quase Sempre	Sempre

7. Estás sozinho quando realizas estes comportamentos? Por favor, assinala uma das opções:

Nunca	Raramente	Algumas Vezes	Quase Sempre	Sempre

8. Onde costumas realizar esses comportamentos? Por favor, assinala uma ou mais opções:

☐ Casa ☐ Escola

☐ Outro Sítio. Qual? _____

9. Normalmente, quanto tempo passa desde o momento em que pensas em fazer estes comportamentos até ao momento em que os fazes realmente? Por favor, assinala uma das opções:

Menos de 1 hora	1 a 3 horas	3 a 6 horas	6 a 12 horas	12 a 24 horas	Mais de um dia

10. Queres ou já quiseste parar estes comportamentos? Por favor, assinala uma das opções:

☐ NÃO ☐ SIM

Porquê? _____
_____

Anexo B: Materiais de "Representations about the Functions of Deliberate Self-Harm from Adults and Adolescents: A Qualitative Study"

Guião da Entrevista – Adolescentes

Questão 1 (Introdução)	**Como sabes, há jovens que têm comportamentos saudáveis e outros menos saudáveis. Gostaria que falasses um pouco sobre isso...**
Questões de *Follow-Up* (Introdução)	- O que é que te vem à cabeça? - O que achas disso? - Que pessoas é que têm esses comportamentos?
Questão 2 (CAL)	**Há outros jovens que têm comportamentos em que se magoam a si próprios intencionalmente, como por exemplo jovens que se cortam ou queimam a eles mesmos. Gostava que falasses sobre isso...**
Questões de *Follow-Up* (CAL)	- O que pensas sobre esses comportamentos? - O que pensas sobre essas pessoas? - O que achas que leva os outros a fazerem isso? - Pensas que existe alguma razão para os jovens fazerem isso? - Em que situações achas que isso acontece? - Achas que esses comportamentos servem para alguma coisa? - O achas que se deve fazer perante essas pessoas? - O que farias se soubesses que um amigo/colega teu tinha esses comportamentos? - Como se poderá ajudar alguém com esses comportamentos?
Questão 3 (Conhecimentos Interpessoais com CAL)	**Conheces alguém que pratique ou tenha praticado esses comportamentos? Fala um pouco sobre essa pessoa...**
Questões de *Follow-Up* (Conhecimentos Interpessoais com CAL)	- Quem é essa pessoa? - Que relação tens com essa pessoa? - Como é essa pessoa? - O que pensaste quando soubeste?
Questão 4 (Final)	**Gostarias de acrescentar mais alguma coisa ao que já foi dito?**

Guião da Entrevista – Adultos

Questão 1 (Introdução)	**Como sabe, há jovens que têm comportamentos saudáveis e outros menos saudáveis. Gostaria que falasse um pouco sobre isso...**
Questões de *Follow-Up* (Introdução)	- O que é que lhe vem à cabeça? - O que acha disso? - Que pessoas é que têm esses comportamentos?
Questão 2 (CAL)	**Há outros jovens que têm comportamentos em que se magoam a si próprios intencionalmente, como por exemplo jovens que se cortam ou queimam a eles mesmos. Gostava que falasse sobre isso...**
Questões de *Follow-Up* (CAL)	- O que pensa sobre esses comportamentos? - O que pensa sobre essas pessoas? - O que acha que leva os jovens a fazerem isso? - Pensa que existe alguma razão para os jovens fazerem isso? - Em que situações acha que isso acontece? - Acha que esses comportamentos servem para alguma coisa? - O acha que se deve fazer perante essas pessoas? - O que faria se soubesse que um amigo/colega seu tinha esses comportamentos? - Como se poderá ajudar alguém com esses comportamentos?
Questão 3 (Conhecimentos Interpessoais com CAL)	**Conhece alguém que pratique ou tenha praticado esses comportamentos? Fale um pouco sobre essa pessoa...**
Questões de *Follow-Up* (Conhecimentos Interpessoais com CAL)	- Quem é essa pessoa? - Que relação tem com essa pessoa? - Como é essa pessoa? - O que pensou quando soube?
Questão 4 (Final)	**Gostaria de acrescentar mais alguma coisa ao que já foi dito?**

Anexo C: Materiais e Medidas de "Representations about the Functions of Deliberate Self-Harm: Construction and Validation of a Questionnaire for Portuguese Adolescents"

Questionário das Representações sobre as Funções dos Comportamentos Auto-Lesivos para Adolescentes – Versão Final (QRFCAL-Adolescentes)

Os **comportamentos em que os jovens se magoam a si próprios intencionalmente** (ou seja, de vontade própria) **têm algumas funções, isto é, servem para alguma coisa**.

A seguir vais encontrar uma lista de afirmações que têm a ver com as funções destes comportamentos. Por favor, assinala o quanto discordas ou concordas com estas afirmações.
Se tiveres praticado estes comportamentos, responde de acordo com a tua experiência.

"Quando os jovens realizam estes comportamentos estão a..."

	Discordo Totalmente	Discordo	Não Concordo Nem Discordo	Concordo	Concordo Totalmente
1. Criar uma fronteira entre eles e os outros					
2. Fazê-lo porque sentem que erraram					
3. Ver se aguentam a dor					
4. Libertar a tensão que têm dentro de si					
5. Tentar sentir alguma coisa (em vez de nada) mesmo que seja dor física					
6. Estabelecer uma barreira entre si e os outros					
7. Procurar o cuidado ou a ajuda de outras pessoas					
8. Trocar a dor de alma pela dor do corpo					
9. Demonstrar que não precisam dos outros para terem ajuda					
10. Diminuir a sua ansiedade, frustração, raiva, ou outras emoções					
11. Tentar sentir-se integrados com as outras pessoas					
12. Ter a certeza de que estão vivos quando não se sentem reais					
13. Aliviar sofrimento psicológico através da dor física					
14. Tentar magoar alguém que lhes é próximo					

	Discordo Totalmente	Discordo	Não Concordo Nem Discordo	Concordo	Concordo Totalmente
15. Demonstrar que são autónomos ou independentes					
16. Fugir de situações em que não querem estar					
17. Organizar as suas ideias					
18. Criar uma dor física para esquecer uma dor psicológica					
19. Fugir aos problemas					
20. Tentar culpar alguém porque não fizeram o que eles queriam					
21. Aliviar o seu sofrimento					
22. Sentir prazer na dor					
23. Tentar pertencer a um grupo de amigos/colegas					
24. Demonstrar que são resistentes ou fortes					
25. Fazê-lo porque se sentem culpados/culpabilizados					
26. Pedir ajuda					
27. Provocar dor para que sintam alguma coisa					
28. Provar a si próprios ou aos outros que aguentam a dor física					
29. Fugir de alguma coisa que não está bem					
30. Responder fisicamente a uma dor emocional					
31. Fazê-lo porque têm necessidade de sentir dor					
32. Fazer com que a família ou os amigos percebam que eles não estão bem					
33. Arrumar os seus pensamentos					
34. Tentar escapar a situações desagradáveis					
35. Substituir o seu sofrimento psicológico através da dor física					

Opcional: Achas que estes comportamentos têm outras funções que não estão nesta lista? Se sim, por favor escreve-as no espaço seguinte.

_____

_____

_____

_____

Questionário Sócio-Demográfico Adolescentes

Por último, pedimos-te que preenchas estes dados:

Género:

☐ Feminino ☐ Masculino ☐ Outro - Qual? _____

Idade: _____ anos

Nacionalidade: _____

Ano de Escolaridade: _____

Já reprovaste alguma vez?

☐ Não ☐ Sim - Quantas vezes? _____ Em que ano(s)? _____

Com quem vives?

☐ Pai e Mãe ☐ Pai, Mãe e Irmão(s) ☐ Outras Pessoas - Quem? _____

☐ Pai ☐ Mãe _____

Tens irmãos?

☐ Não ☐ Sim - Quantos? ____ Com que idade? _____

Se tiveres irmãos, és o irmão:

☐ Mais Novo ☐ Do Meio ☐ Mais Velho ☐ Gémeo

Os teus pais são:

☐ Solteiros ☐ Casados ☐ Em União de Facto

☐ Divorciados ☐ Viúvo(a) ☐ Outro - Qual? _____

Os teus pais estudaram até que ano?

Pai: _____ Mãe: _____

Qual a profissão dos teus pais?

Pai: _____ Mãe: _____

Já alguma vez tiveste problemas do psicológicos?

☐ Não

☐ Sim - Porquê? _____

Já alguma vez tiveste consultas de:

☐ Psicologia

☐ Psiquiatria

Porquê? _____

Conheces alguém que se tenha tentado suicidar?

☐ Não

☐ Sim - Quem?

☐ Amigos

☐ Conhecidos

☐ Colegas

☐ Família - Quem? _____

☐ Outra Pessoa - Quem? _____

Conheces alguém que tenha comportamentos em que se magoa a si próprio (como cortar-se, queimar-se, etc)?

☐ Não

☐ Sim - Quem?

☐ Amigos

☐ Conhecidos

☐ Colegas

☐ Família - Quem? _____

☐ Outra Pessoa - Quem? _____

Obrigado pela tua participação!

Esquema de Dimensões e Itens do QRFCAL-Adolescentes

Funções Interpessoais		Itens
Autonomia & Resistência	**Autonomia**	**9.** Demonstrar que não precisam dos outros para terem ajuda **15.** Demonstrar que são autónomos ou independentes
	Resistência	**3.** Ver se aguentam a dor **24.** Demonstrar que são resistentes ou fortes **28.** Provar a si próprios ou aos outros que aguentam a dor física
Fronteiras/Limites Interpessoais		**1.** Criar uma fronteira entre eles e os outros **6.** Estabelecer uma barreira entre si e os outros
Influência Interpessoal		**7.** Procurar o cuidado ou a ajuda de outras pessoas **26.** Pedir ajuda **32.** Fazer com que a família ou os amigos percebam que eles não estão bem
Ligação com os Pares		**11.** Tentar sentir-se integrados com as outras pessoas **23.** Tentar pertencer a um grupo de amigos/colegas
Vingança		**14.** Tentar magoar alguém que lhes é próximo **20.** Tentar culpar alguém porque não fizeram o que eles queriam

Funções Intrapessoais	Itens
Anti-Dissociação ou Geração de Sensações	**5.** Tentar sentir alguma coisa (em vez de nada) mesmo que seja dor física **12.** Ter a certeza de que estão vivos quando não se sentem reais **22.** Sentir prazer na dor **27.** Provocar dor para que sintam alguma coisa **31.** Fazê-lo porque têm necessidade de sentir dor
Auto-Punição	**2.** Fazê-lo porque sentem que erraram **25.** Fazê-lo porque se sentem culpados/culpabilizados
Auto-Regulação do Afecto	**4.** Libertar a tensão que têm dentro de si **10.** Diminuir a sua ansiedade, frustração, raiva, ou outras emoções **21.** Aliviar o seu sofrimento
Mecanismo de Fuga	**16.** Fugir de situações em que não querem estar **19.** Fugir aos problemas **29.** Fugir de alguma coisa que não está bem **34.** Tentar escapar a situações desagradáveis
Meio Introspectivo	**17.** Organizar as suas ideias **33.** Arrumar os seus pensamentos
Substituição de Sofrimento Psicológico por Dor Física	**8.** Trocar a dor de alma pela dor do corpo **13.** Aliviar sofrimento psicológico através da dor física **18.** Criar uma dor física para esquecer uma dor psicológica **30.** Responder fisicamente a uma dor emocional **35.** Substituir o seu sofrimento psicológico através da dor física

Anexo D: Materiais e Medidas de "Representations about the Functions of Deliberate Self-Harm: Construction and Validation of a Questionnaire for Portuguese Adults"

Questionário das Representações sobre as Funções dos Comportamentos Auto-Lesivos para Adultos – Versão Final (QRFCAL-Adultos)

Os **comportamentos em que os jovens se magoam a si próprios intencionalmente** (ou seja, de vontade própria) **têm algumas funções, isto é, servem para alguma coisa**.

A seguir vai encontrar uma lista de afirmações que têm a ver com as funções destes comportamentos. Por favor, assinale o quanto discorda ou concorda com estas afirmações.

"Quando os jovens realizam estes comportamentos estão a..."

	Discordo Totalmente	Discordo	Não Concordo Nem Discordo	Concordo	Concordo Totalmente
1. Acalmar-se					
2. Criar uma fronteira entre eles e os outros					
3. Castigar-se					
4. Dar-se um motivo para cuidar de si (ao tratar da ferida)					
5. Provocar dor para que sintam alguma coisa					
6. Evitar o desejo de se suicidarem					
7. Criar uma ligação com os seus amigos/colegas					
8. Dar a conhecer aos outros o tamanho da sua dor					
9. Ver se aguentam a dor					
10. Vingar-se de alguém					
11. Provar que são capazes de fazer coisas sozinhos					
12. Libertar a tensão que têm dentro de si					
13. Mostrar a raiva que sentem por si mesmos					
14. Tentar sentir alguma coisa (em vez de nada) mesmo que seja dor física					
15. Reagir a pensamentos suicidas sem se tentarem suicidar					
16. Tentar sentir-se integrados com as outras pessoas					

	Discordo Totalmente	Discordo	Não Concordo Nem Discordo	Concordo	Concordo Totalmente
17. Procurar o cuidado ou a ajuda de outras pessoas					
18. Demonstrar que são resistentes ou fortes					
19. Provar a si próprios que a sua dor emocional é real					
20. Demonstrar que não precisam dos outros para terem ajuda					
21. Diminuir a sua ansiedade, frustração, raiva, ou outras emoções					
22. Estabelecer uma barreira entre si e os outros					
23. Concentrar-se no tratamento da ferida, o que pode ser compensador ou satisfatório					
24. Ter a certeza de que estão vivos quando não se sentem reais					
25. Acabar com os seus pensamentos suicidas					
26. Ter uma marca que represente a ligação que têm com os seus amigos ou com a sua família					
27. Provar a si próprios ou aos outros que aguentam a dor física					
28. Dar significado ao sofrimento emocional que estão a sentir					
29. Demonstrar que são autónomos ou independentes					
30. Reagir ao sentimento de nojo em relação a si mesmos					
31. Chamar a atenção					
32. Criar uma dor física para esquecer uma dor psicológica					
33. Fugir aos problemas					
34. Isolar-se nos nos seus pensamentos					
35. Penalizar-se por algo que aconteceu					
36. Tentar pertencer a um grupo de amigos/colegas					
37. Fazer com que os outros sintam que devem fazer alguma coisa					
38. Dar um grito de vingança					
39. Trocar a dor de alma pela dor do corpo					
40. Pôr a cabeça noutros mundos					

	Discordo Totalmente	Discordo	Não Concordo Nem Discordo	Concordo	Concordo Totalmente
41. Fazê-lo porque sentem que erraram					
42. Centrar-se no seu mundo interior					
43. Fugir de alguma coisa que não está bem					
44. Responder fisicamente a uma dor emocional					
45. Fazê-lo porque se sentem culpados/culpabilizados					
46. Fazer com que a família ou os amigos percebam que eles não estão bem					
47. Arrumar os seus pensamentos					
48. Tentar escapar a situações desagradáveis					
49. Substituir o seu sofrimento psicológico através da dor física					

Opcional: Acha que estes comportamentos têm outras funções que não estão nesta lista? Se sim, por favor escreva-as no espaço seguinte.

_____

_____

_____

Questionário Sócio-Demográfico Adultos

Por último, pedimos-lhe que preencha estes dados:

Qual a sua relação com o educando?

☐ Pai ☐ Padrasto ☐ Outro - Qual? _____

☐ Mãe ☐ Madrasta _____

Género:

☐ Feminino ☐ Masculino

Idade: _____

Nacionalidade: _____

Habilitações Literárias: _____

Profissão: _____

Por quantas pessoas é composto o seu agregado familiar? _____

Qual o seu Estado Civil?

☐ Solteiro ☐ Em União de Facto ☐ Divorciado

☐ Casado ☐ Viúvo ☐ Outro - Qual? _____

Com quem vive?

☐ Sozinho ☐ Companheiro/Cônjuge e Filho(s)

☐ Companheiro/Cônjuge ☐ Outras Pessoas - Quem? _____

Tem filhos?

☐ Não ☐ Sim - Quantos? ____ Com que idade? _____

Tem irmãos?

☐ Não ☐ Sim - Quantos? ____ Com que idade? _____

Se tiver irmãos, é o irmão:

☐ Mais Novo ☐ Do Meio ☐ Mais Velho ☐ Gémeo

Já alguma vez teve problemas do foro Psicológico?

☐ Não

☐ Sim - Qual o motivo? _____

Já alguma vez recorreu a consultas de:

☐ Psicologia

☐ Psiquiatria

Qual o motivo? _____

Qual o diagnóstico? _____

Conhece alguém que se tenha tentado suicidar?

☐ Não

☐ Sim - Quem?

☐ Amigos ☐ Família - Quem? _____

☐ Vizinhos ☐ Outra Pessoa - Quem? _____

Já alguma vez se tentou suicidar?

☐ Não

☐ Sim

Quantas vezes? _____

Qual o motivo? _____

Conhece alguém que tenha comportamentos auto-lesivos (comportamentos em que alguém se magoa intencionalmente, como cortar-se, queimar-se, etc)?

☐ Não

☐ Sim - Quem?

☐ Amigos ☐ Família - Quem? _____

☐ Vizinhos ☐ Outra Pessoa - Quem? _____

Já alguma vez realizou estes comportamentos?

☐ Não

☐ Sim

Quantas vezes? _____

Qual o motivo? _____

Obrigada pela sua colaboração!

Esquema de Dimensões e Itens do QRFCAL-Adultos

Funções Interpessoais		Itens
Autonomia & Resistência	**Autonomia**	**11.** Provar que são capazes de fazer coisas sozinhos **20.** Demonstrar que não precisam dos outros para terem ajuda **29.** Demonstrar que são autónomos ou independentes
	Resistência	**9.** Ver se aguentam a dor **18.** Demonstrar que são resistentes ou fortes **27.** Provar a si próprios ou aos outros que aguentam a dor física
Fronteiras/Limites Interpessoais		**2.** Criar uma fronteira entre eles e os outros **22.** Estabelecer uma barreira entre si e os outros
Influência Interpessoal		**8.** Dar a conhecer aos outros o tamanho da sua dor **17.** Procurar o cuidado ou a ajuda de outras pessoas **31.** Chamar a atenção **37.** Fazer com que os outros sintam que devem fazer alguma coisa **46.** Fazer com que a família ou os amigos percebam que eles não estão bem
Ligação com os Pares		**7.** Criar uma ligação com os seus amigos/colegas **16.** Tentar sentir-se integrados com as outras pessoas **26.** Ter uma marca que represente a ligação que têm com os seus amigos ou com a sua família **36.** Tentar pertencer a um grupo de amigos/colegas
Vingança		**10.** Vingar-se de alguém **38.** Dar um grito de vingança

Funções Intrapessoais	Itens
Anti-Dissociação ou Geração de Sensações	**5.** Provocar dor para que sintam alguma coisa **14.** Tentar sentir alguma coisa (em vez de nada) mesmo que seja dor física **24.** Ter a certeza de que estão vivos quando não se sentem reais
Anti-Suicídio	**6.** Evitar o desejo de se suicidarem **15.** Reagir a pensamentos suicidas sem se tentarem suicidar **25.** Acabar com os seus pensamentos suicidas
Auto-Cuidado	**4.** Dar-se um motivo para cuidar de si (ao tratar da ferida) **23.** Concentrar-se no tratamento da ferida, o que pode ser compensador ou satisfatório
Auto-Punição	**3.** Castigar-se **13.** Mostrar a raiva que sentem por si mesmos **30.** Reagir ao sentimento de nojo em relação a si mesmos **35.** Penalizar-se por algo que aconteceu **41.** Fazê-lo porque sentem que erraram **45.** Fazê-lo porque se sentem culpados/culpabilizados

Funções Intrapessoais	Itens
Auto-Regulação do Afecto	**1.** Acalmar-se **12.** Libertar a tensão que têm dentro de si **21.** Diminuir a sua ansiedade, frustração, raiva, ou outras emoções
Mecanismo de Fuga	**33.** Fugir aos problemas **43.** Fugir de alguma coisa que não está bem **48.** Tentar escapar a situações desagradáveis
Meio Introspectivo	**34.** Isolar-se nos nos seus pensamentos **40.** Pôr a cabeça noutros mundos **42.** Centrar-se no seu mundo interior **47.** Arrumar os seus pensamentos
Simbolização do Sofrimento	**19.** Provar a si próprios que a sua dor emocional é real **28.** Dar significado ao sofrimento emocional que estão a sentir
Substituição de Sofrimento Psicológico por Dor Física	**32.** Criar uma dor física para esquecer uma dor psicológica **39.** Trocar a dor de alma pela dor do corpo **44.** Responder fisicamente a uma dor emocional **49.** Substituir o seu sofrimento psicológico através da dor física