ORIGINAL ARTICLE

Prevalence and help-seeking behaviour for non-suicidal self-injury in college students

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ABSTRACT

The prevalence of NSSI has become a widespread health problem in various countries. There is a scarcity of research pertaining to NSSI in Eastern countries, in comparison to studies undertaken in Western countries. This study aims to explore the self-injurious behaviour of college students in Indonesia. The crowdsourcing approach was applied by way of distributing questionnaires via Google Forms. A total of 909 college students aged 18-25 years (mean age = 20.3, SD = 1329, 75.4% female) completed the ISAS self-report scale to assess NSSI**.** Participants were recruited throughout June–July 2022. Results indicated that 30% of college students engaged in NSSI behaviour. The mean age of onset is 15.5 years. Reported methods relating to NSSI include hair pulling (78.0%), banging (74.4%), and pinching (66.0%). It was reported that 88.3% used more than one method and 17.2% felt no pain during self-injury. In carrying out NSSI, 72.5% did it alone. Additionally, it was mentioned that 73.6% had self-injured within the last year. Participants reported not sharing their experiences of NSSI (60.1%) due to fear of a negative reaction and a fear of being perceived as attention seeking. For NSSI function, the highest scores were Affect Regulation 6.76 (SD=2.22), Self-Punishment 5.84 (SD=2.65) and Anti-suicide 5.42 (SD=2.64). Concerning gender, results revealed statistically significant differences in the following subscales: Affect Regulation ($p<0.05$), Anti Dissociation ($p<0.05$) Anti-suicide ($p<0.05$) and Marking Distress ($p <0.05$). In conclusion, NSSI is still a public health issue in Indonesia. The majority of NSSI students did not have help-seeking behaviour. Prevention and management measures need to be developed to support people who self-injure by developing strategies to enable them to deal with problems appropriately and avoid risky behaviour.

Key words:
collage student, help-seeking non-suicidal self injury; prevalence

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INTRODUCTION

Non-suicidal self-injury is the act of self-injury that is performed intentionally and repeatedly without the intention to commit suicide or sexual intention and without social acknowledgment[1]. Furthermore, the act of self-injury is not carried out deliberately for aesthetic reasons, e.g., tattoo, piercing, etc. Brown & Plener[2] stated that the issue of NSSI among adolescents is considered a common and significant public health problem. In recent years, the occurrence of NSSI has increased both in terms of growth rates and cases of NSSI in Eastern countries, such as Korea[3,4], India[5,6] and China[7,8]. Regrettably, there are very few studies related to self-injury in Eastern countries, in contrast to those completed in the West[9]. In Indonesia, studies concerning NSSI remain extremely limited, notwithstanding that NSSI is becoming a serious societal health problem for the reason that several studies have established that NSSI is associated with a risk of suicide.[10–13]

Self-injury is undertaken for various reasons. In their investigation, Cipriano et al.[14] determined that the reason why teenagers carried out NSSI was because of their anger towards themselves. This is similar to the study conducted by Klonsky et al.[15] who ascertained that self-injury is an expression of anger, disappointment and punishment of oneself as well as communicating to the environment about the pain. Self-injury is believed to be able to reduce negative feelings. This is supported by the findings obtained by Taylor et al.[16] who asserted that certain individuals self-injure in order to achieve peace. Previous research conducted by Sim et al.[17] discovered that the regulation of internal emotion was the most frequently reported reason for adolescents self-injuring. In-Albon et al.[18,] and Laporte et al. [19] both established that reasons for NSSI are related to emotion regulation. Qualitative research conducted by Arinda and Mansoer[20] discovered that NSSI was carried out to overcome feelings of emptiness and negative emotions. This is consistent with the results of an initial survey conducted by researchers which ascertained that women were more likely to perform NSSI with the intention of regulating their emotions. In male respondents, the most obvious reason is an attempt to punish themselves. Previous research identifies other reasons, but to a lesser extent, for instance interpersonal boundaries, sensation seeking, anti-suicide, anti-dissociation and autonomy.[21]

NSSI can occur in practically any age range, from childhood to adulthood. A study conducted by Li et al. [22] in China found that 14.84% of elementary school children had committed NSSI as a result of bullying in schools. The study completed by Glenn & Klonsky[23] determined that most incidents of self-injury occurred in adolescence and early adulthood and that it had a prevalence rate of 37-50%. This finding is supported by several studies. For example, Cerutti et al.[24] realised that as many as 42% of adolescents are involved in NSSI behaviour. A similarly high rate of 32.2% occurred in adolescents in Spain who demonstrated severe NSSI behaviour[25]. A systematic review conducted by Swannell et al.[26] specifically classified the prevalence of NSSI in different age groups to be 17.2% in adolescents, 13.4% in young adults and 5.5% in adults.

Cases of NSSI are also exceptionally high in students. Several studies have identified a relatively large number of college students who commit self-injury. Research conducted by Whitlock et al.[27] in a non-clinical setting with a sample of college students, discovered that lifetime prevalence rates

ranged from 17–38%. In a further study, it was reported that 36.1% of students in Leuven, Belgium had self-injured during their studies[28]. Cipriano et al.[29] determined that 38.9% of college students had committed self-injurious behaviour at least once in their life. Naidoo[30] found a higher number of students in South Africa, namely 56.2% had committed self-injury once in their life. Kiekens et al. [28] confirmed that college years pose a high risk for the onset of NSSI. Their study established that the first on-set is as much as 10.3% in the first year and 6.0% in the second year. 8.6% reported sporadic NSSI (1–4 times per year) and 7.0% reported recurrent NSSI up to five times per year during the first two years of college.

NSSI is not only associated with a variety of negative mental health impacts, but it can also have significant consequences for others. A person must pay for treatment for NSSI. However, it is important to note that one of the causes of NSSI pertains to financial concerns[31]. It should be mentioned that NSSI is exacerbated by the reluctance to seek help from both the immediate and professional environment. Based on the findings of Ystgaard et al.[32], individuals are still failing to seek professional support. Out of 1,660 participants, it was ascertained that 48.4% did not seek assistance after the last episode of self-injury and only 18.8% obtained professional services. The factor that hinders individuals from seeking help is typically a fear of negative reactions from others including stigmatisation, fear of confidentiality being violated and a fear of being seen as attention seeking[33].

Most adolescents who engage in NSSI represent unseen populations who do not receive professional support because the process of seeking help is problematic for individuals who carry out NSSI.[34] Rowe et al.[33] learnt that one third to half of teenagers do not seek support for self-injurious behaviour. According to Baetens et al.[35] only 17% of adolescents with NSSI received professional support. Doyle et al.[36] confirmed that only 9% of adolescents sought help prior to self-injury and 6.4% of youths were taken to hospital after committing self-harm. The study by Wang et al.[37] uncovered that in developing countries, service use is commonly lower than in developed countries.

Data regarding NSSI shows an increasing trend globally, including in developing countries. A systematic study conducted by Thippaiah et al.[38] regarding the prevalence of NSSI in developing countries, obtained a variety of results, ranging from 11.5% to 33.8 % . Unfortunately, there are not as many studies focusing on self-injury in Eastern countries as there are in the West[39]. Likewise in Indonesia, only a few studies have been undertaken to determine the prevalence rate connected with NSSI. As with the iceberg phenomenon, it is difficult to find data that genuinely presents the number of survivors of NSSI unless they are being treated for other psychiatric conditions, such as depression or anxiety[40]. In an attempt to protect students from carrying out NSSI, extensive research should be conducted to uncover whether there is NSSI behaviour among students in Indonesia. In contrast to previous research conducted by Tresno et al.[41] which involved 314 students, the current research involves a larger number of respondents who are expected to be more representative. Additionally, it will also provide information concerning the respondents' demographic characteristics, functions of NSSI and help-seeking behaviour that was not disclosed in previous research. The aim of the current study is to examine the

prevalence and characteristics of NSSI, in addition to NSSI function, including help seeking behaviour among students in Indonesia. To measure the NSSI and method of self-injury, the Inventory of Statements About Self-Injury (ISAS)[42] was used. ISAS has been employed in several studies[23,43–45] and its validity has been determined.[15, 36-38]

METHOD

Participants

Data collection was carried out online by involving students throughout Indonesia using the "crowdsourcing" method. The inclusion criteria were (1) students, (2) aged 18 - 25 years. During the study period, 959 responses were obtained. After removing incomplete data as well as data that did not meet the inclusion criteria (5%), the data analysed comprised 909 students (685 female and 224 male), aged 18-25 years (Mean = 20.3, SD = 1.3293), science major 38% (n= 346), social major 40.26% (n=366) and health 21.67% (n=197). The majority live in urban areas (67.8%), have a mother and father who live together (87.2%) and also live with their families (78%).

Instrument

Assessment of the level, methods, functions and characteristics of NSSI using the Inventory of Statements About Self-injury (ISAS)[42] was modified for use with Indonesian students. This was performed because the researchers considered language and cultural differences in the translation process; therefore, modifications were made. Prior to use, 136 students were tested and a relatively high Cronbach's alpha score was attained. This ISAS scale was equivalent to 0.84 for the first part and 0.988 for the second part.

This instrument consists of two parts. The first part assesses the frequency of self-injury behaviour that has been completed throughout the life of 12 NSSI behaviours that were carried out "on purpose, i.e., on purpose and without suicidal intent". The behaviours assessed involve cutting, severe scratching, biting, banging or hitting self, burning, interfering w/ wound healing (e.g., picking scabs), carving, rubbing skin against a rough surface, pinching, sticking self w/ needles, pulling hair, swallowing dangerous substances. There were additional questions with respect to descriptive and contextual factors, including age at the time of committing self-injury, experience of pain during self-injury, whether self-injuring was done alone or around others, time between the emergence of the urge to self-injure and his/her actions, whether the individual wants to stop being involved in this behaviour, whether to tell others, whom to tell and the reason for not telling. Part two contains 13 functions relating to self-injurious behaviour consisting of intrapersonal and interpersonal functions. The second part makes use of a Likert scale. In their research, Zade & Motjtabaie[46] mentioned that this section can evaluate self-injurious behaviour which has been confirmed in 62 experimental and theoretical studies. Hence, this scale can be used to determine self-injurious behaviour. The second section assesses 13 potential functions of the NSSI: affect regulation, interpersonal boundaries, self-punishment, self-care, anti-dissociation, anti-suicide, sensation seeking, peer-bonding, interpersonal influence, toughness, marking distress, revenge, and autonomy. Each function consists of four distinctive options rated as "0-Highly Disagree", "1-Disagree", "2-Agree" and "3-Highly Agree" with "self-injury [non-suicidal] experiences". Thus, the score for each of the 13 ISAS functions can range from 0 to 4. There are 39 preferred statements with

four alternative answers for each statement item.

To assess help-seeking behaviour, the following questions were employed: (1) Have you ever told someone or requested help from others regarding this problem? (2) If not, what were the reasons that deterred you?

Procedure

Students were recruited for this specific piece of research using the crowdsourcing method. Data collection was carried out from July to August 2020 using a Google form which was disseminated throughout Indonesia by means of social media networks, such as WhatsApp, Facebook and Line. Prior to completing the survey, participants completed an online consent form. After providing consent, participants completed a series of online questionnaires. This research received ethical approval from the Research Ethics Committee of the Faculty of Medicine, Sebelas Maret University (Number: 36/UN27.96.11/KEP/EC/2022).

Data analysis

Statistical descriptions were conducted to analyse the frequency and characteristics of students' participation with regard to NSSI behaviour. The researcher analysed the descriptive test and non-parametric difference test using the Mann Whitney formula. Data analysis was executed using SPSS 22. The study of the structure of the function of NSSI items was performed by examining the responses of students who had reported at least one NSSI act over the past 12 months.

RESULT

The use of anonymity in research is essential when sensitive issues are being investigated. This study obtained a total sample of 909 students (224 males and 685 females), with a mean age of 20.3 (SD = 1.39) years. The characteristics of participants who completed the questionnaire consisted of students with a science major 38.1%, students with a social major 40.3%, along with 21.6% from a health major. The majority of participants reside in urban areas (67.8%) and belong to middle economic status (33.7%), living with parents (78%) and have a father and mother who live together (87.2%).

Table 1. Participants' characteristics

Category	NSSI				Total		*p value*
	Yes		No				
	Total	%	Total	%	Total	%	
Gender							.035
Female	219	24	466	51.3	685	76	
Male	54	6	170	18.7	224	24	
Total	273	30	636	70	909	100	
Age							.000
18-20	197	21.8	415	45.6	612	67.4	
21- 25	76	8.3	221	24.3	297	32.6	
Household income							.000
Very Low	46	5	109	12	155	17	
Low	102	11.2	166	18.3	268	29.5	
Middle	58	6.4	248	27.3	306	33.7	

Category	NSSI				Total		*p value*
	Yes		No				
	Total	%	**Total**	%	**Total**	%	
High	40	4.4	51	5.6	91	10	
Very High	27	3	62	6.8	89	9.8	
Field of study							.416
Science major	96	10.6	250	27.5	346	38.1	
Social major	93	10.3	273	30	366	40.3	
Health	84	9.2	113	12.4	197	21.6	
Place of living							.712
Rural	69	7.6	224	24.6	293	32.2	
Urban	204	22.5	412	45.3	616	67.8	
House							.178
Joint-family	206	22.7	503	55.3	709	78	
Boarding	67	7.4	133	14.6	200	22	
Parental status							.361
Single parent	46	5.1	70	7.7	116	12.8	
Complete	226	24.8	567	62.4	793	87.2	

The findings shown in Table 1 illustrate the respondents' demographic characteristics. The study involved 909 respondents. It established that 30% (n = 273) of college students had a history of self-harm at least once in their lifetime. A total of 73.6% (n = 201) of students were still carrying out NSSI in the past year. The majority of those with a history of self-injury were women 24% (n = 219). In terms of socioeconomic status, the highest occurrence (11.2%) was in the lower social class (2–4.9 million/month). According to the findings, there is no significant difference in the demographic characteristics of students who live in urban or rural areas, at home, in the field of study or parental status regarding those who carry out and those who do not carry out NSSI.

The methods reported the most are hair pulling (78%) and banging or hitting (74.4%). Other behaviours that are demonstrated included pinching (66%), biting (57.1%) and interfering with wound healing (46.9%). The methods reported the least comprised ingesting hazardous substances (7.3%) and burning (5.5%). A total of 88.3% (n = 241) utilised more than one method for self-harming (Table 2).

Table 2. NSSI Method

***Self-Injury* Method**	**Total N=273**	
	F	**P (%)**
Hair pulling	213	78
Banging and hitting	203	74.4
Pinching	180	66
Biting	156	57.1
Interfering wound healing	128	46.9
Scratching skin roughly	113	41.3
Cutting	74	27.1
Skin carving	73	26.7
Needle pricking body part	69	25.2
Rubbing skin on rough surface	60	22
Ingesting hazardous substance	20	7.3
Burning	15	5.5
Number of *Self-Injury* methods		
Single way	32	11.7
Multiple ways	241	88.3

Table 3 presents a summary of the participants' identified NSSIs. As many as 73.6% (n = 201) of students had undertaken NSSI in the last year. Most participants had recurrent NSSIs. The highest prevalence is in the 15-17 age group (37%). On average, self-injury began at 15.49 years of age (SD = 4.15). Regarding the participants, 17.2% reported no aches/pains, whereas 28.8% reported feeling pain. However, the vast majority (54.2%) informed that they occasionally experience pain when hurting themselves. Regarding planning the self-injury**,** most of the participants stated that they engaged in NSSI behaviour by thinking about it for less than an hour (72.5%). Other participants asserted that they considered it for hours (less than a day) and for several days (21.2% and 5.1% respectively). The majority commit self-harm when alone (78%), while 90% said they wanted to stop performing the act of NSSI.

Table 3. Contextual Factors relating to NSSI survivors

Category	**N = 273**	
	F	**P**
Frequency		
Once	18	6.6 %
2 – 50 times	103	37.73 %
51 – 200 times	83	30.4 %
201 – 500 times	36	13.19 %
>500 times	33	12.09 %

Category	N = 273	
	F	P
First onset age		
3 – 11 years	28	10.3%
12 – 14 years	40	14.7 %
15 – 17 years	101	37 %
18 – 20 years	84	30.8 %
> 20 years	11	4 %
Information not provided	9	3.2%
Physical pain sensation		
Feel no pain	47	17.2 %
Feeling pain	78	28.6 %
Occasionally	148	54.2 %
Circumstances when self-harming		
Alone	214	78.4%
Not alone	18	6.6 %
Occasionally	41	15 %
The length of time from intention to actually self-harming		
< 1 hour	198	72.5 %
1– 24 hours	58	21.2%
> 1 day	17	6.2 %
Last time engaged in NSSI (offset)		
1 - 12 months	201	73.6%
>12 months	70	25.6 %
Did not explain	2	0.73%
Wish to stop NSSI		
Yes	246	90.1%
No	26	9.5%

Table 4 provides a summary of help-seeking behaviour. Most (60.1%) of those who had experience with NSSI did not seek professional help. Moreover, 33.3% did not tell loved ones (non-professionals) about their NSSI. They are also reluctant to disclose their NSSI for various reasons, such as a fear of other people's negative responses (29%), fear that they will be suspected of being attention seeking (27%), their NSSI behaviour is considered insignificant and harmless (8.42%) and also concerns that their confidentiality will be violated (5.86%). Consequently, they tend to withhold this valuable information (5.13%). Likewise, if they inform someone, they are worried that the sensitive information will burden others (3.3%). Furthermore, a number of individuals actually believe that they have no friends to confide in (2.9%).

Table 4. Help-seeking behaviour

Seeking help	**N**	**%**
Professional	15	6.6%
Non-professional	79	33.3%
Not seeking help	161	60.1%
Did not explain	18	6.6%
Reasons for not revealing		
Fear of other people's negative reactions	79	29%
Fear of being thought of as attention seeking	74	27%
It's not a dangerous act so it is not important to mention	23	8.42%
Fear of confidentiality being violated	16	5.86%
Keep it private/private	14	5.13%
Do not want to be a burden	9	3.3%
No friend to confide in/alone	8	2.9%

On the subject of NSSI function, the highest scores were Affect Regulation 6.76 (SD=2.22), Self-Punishment 5.84 (SD=2.65) and Anti-suicide 5.42 (SD=2.64) (see Table 5). Among female respondents, the highest score was for Affect Regulation 6.92 (SD=2.11), Self-Punishment 5.94 (SD=2.61) and Anti-suicide 5.63 (SD=2.51). The highest score among male respondents was for Affect Regulation 6.13 (SD=2.56), self-punishment 5.41 (SD=2.78) and Interpersonal Boundaries 5.04 (SD=2.70) (see Table 5).

Concerning gender, the results exhibited statistically significant differences in the following subscales: Affect Regulation ($p<0.05$), Anti Dissociation ($p<0.05$), Anti-suicide ($p<0.05$) and Marking Distress ($p<0.05$) (see Table 5).

Table 5. ISAS function as measured by ISAS based on gender

	Gender	Mean	Std. Deviation	p	Total	Std. Deviation
Affect Regulation	Female	6.92	2.11	0.02	6.76	2.23
	Male	6.13	2.56			
Interpersonal Boundaries	Female	5.44	2.38	0.28	5.36	2.45
	Male	5.04	2.70			
Self-Punishment	Female	5.94	2.66	0.19	5.84	2.65
	Male	5.41	2.78			
Self-Care	Female	4.38	2.57	0.13	4.26	2.61
	Male	3.78	2.74			
Anti-Dissociation	Female	5.08	2.55	0.04	4.92	2.55
	Male	4.30	2.49			
Anti-suicide	Female	5.63	2.51	0.01	5.42	2.64
	Male	4.54	2.98			
Sensation-Seeking	Female	3.35	2.51	0.26	3.26	2.49
	Male	2.93	2.37			
Peer Bonding	Female	2.66	2.47	0.78	2.68	2.45
	Male	2.76	2.42			
Interpersonal Influence	Female	2.56	2.450	0.46	2.61	2.45
	Male	2.83	2.440			
Toughness	Female	4.54	2.637	0.19	4.44	2.64
	Male	4.02	2.617			
Marking Distress	Female	5.11	2.439	0.03	4.94	2.50
	Male	4.28	2.674			
Revenge	Female	1.93	2.366	0.69	1.96	2.40
	Male	2.07	2.583			
Autonomy	Female	4.40	2.698	0.63	4.36	2.72
	Male	4.20	2.838			

DISCUSSION

The issue of non-suicidal self-injury (NSSI) is repeatedly reported as the inappropriate behaviours of adolescents. The study ascertained that 30% of students had reported engaging in self-harming at least once in their lifetime. The results of a previous study conducted in Indonesia by Tresno et al.[41] discovered a higher number of 38%. A higher figure was also found in the study conducted by Galicia & Bautista [47], who established a prevalence rate of 49.33%. In contrast, the results obtained by Gandhi et al.'s study[5] showed a lower number, approximately 21%. The meta-analytical study performed by Swannel et al. [26] discovered differences in prevalence rates in various studies, despite the fact that the research was conducted on homogeneous subjects. The use of different measurement tools is one of the reasons for the difference in prevalence rates[48], such as the use of a single response (yes and no), which is considered less accurate in measuring NSSI. In this study, the measurement of NSSI was carried out using an Inventory of Statements About Self-

injury[49] which has a more comprehensive checklist to reveal events related to NSSI. The current study uncovered no differences in self-injurious behaviour in several demographic factors, for instance urban or rural, at home, field of study, as well as parental status between students with and without experience of NSSI. This result is in line with the research completed by Verroken et al.[50] that indicated family factors, i.e. accompanied or not, having both parents are significantly associated with NSSI. The findings obtained by Plener et al. [51] in Germany found no differences in the frequency of NSSI, with respect to those who live in urban areas and those who live in rural areas.

Concerning gender differences, there are variations in relation to findings. A handful of studies illustrated a lower prevalence in men. Conversely, certain research emphasises that the prevalence is greater in men than in women. Moreover, it was even established that the results of the study did not reveal any difference. The current study determined a significant difference between women and men. The results of this study are consistent with research by Lutz et al.[52] who identified that there is a significant difference between women and men, with higher rates observed in women than in men. The same result was also confirmed by Wilkinson et al.[53] who found a higher occurrence in women in comparison to men. According to Swannell et al.,[26] women are more vulnerable to negative emotions, which are the most likely risk factors regarding self-harm. Contrary to the opinion of Bresin & Schoenleber[54] who argued that a smaller number of male participants were involved in reporting a history of NSSI, Poudel et al.[13] discovered that men were more likely to be involved in NSSI than women. This is different from the findings obtained by Yang & Feldman[55] which stated that there is no gender difference in relation to the act of NSSI. It was further explained that gender differences in NSSI are not permanent and will change with the development and maturity of age, so that NSSI behaviour will generally disappear in early adulthood.

Regarding the age of onset or the first act of self-injury, this study identified that the average age was 15.49 years (SD = 4.15). This is consistent with the study undertaken by Gandhi et al.[56], which ascertained that the average age of onset in adolescents is 14-15 years. This result is in line with the findings disclosed by Muehlenkamp et al.[57], which stated that early adolescence is a critical age so that there is the potential for problems to arise. Several respondents reported that the age of onset was under 12 years of age (10.30%). Concerning this early onset, age is also reported by Li et al.[22], who maintained that as many as 14.48% of elementary school children have committed NSSI as the result of bullying in school. In fact, starting to engage in self-injury at a younger age is an indicator of severe NSSI and increases the chances of suicide occurring.[57,58]

Considering socioeconomic status, the results of our study noted that there was an inverse relationship, the lower the economic level the higher the NSSI. This is consistent with the previous findings[3,59] that demonstrated economic status as a factor related to NSSI. According to a study carried out by Wu & Liu[60], socio-economic constraints can indicate that a person is encountering further problems, thus the act of self-injury is triggered.

The most commonly reported methods are hair pulling, banging or hitting, and pinching. The current study is similar to several previous studies performed in other countries[13,61,62], which maintain that the NSSI method most commonly used is hair pulling. However, differences are noted with the results of previous studies

conducted in Indonesia by Tresno et al.[41], who reported that cutting is the most frequent act of self-injury. According to several studies[39,63] culture plays a role in the acceptance of behaviour included in the NSSI method. Indonesia covers a vast geographical area. The current research involves respondents from various provinces, while previous research employed only one university, so it is extremely possible that the differences in NSSI methods may be influenced by culture, as You & Leung[63] claim. The majority of people involved in self-injury in our study exploited more than one method in repeated episodes (88.3%). This necessitates serious consideration because the use of numerous NSSI methods is expected to increase the probability of suicide attempts.[64]

Impulse control problems are often associated with NSSI problems[65]. Emotional situations can increase the risk of undertaking impulsive acts, which can trigger inappropriate acts, such as self-harm[66]. The current study ascertained relatively short time intervals (less than an hour) between thoughts and acts of self-injury. Individuals who have difficulty controlling their impulses when stressed are more likely to engage in self-destructive acts, for example NSSI. They employ self-harm strategies to reduce the negative affect. Essentially, the time between the appearance of a desire and actual action can be used to think rationally and avoid impulsive behaviour, such as NSSI. This pattern of rational behaviour can be enhanced by consistent training so that people can prevent and avoid self-injury.

A number of self-injury survivors deny that they experience pain when they carry out self-injury. It is important to state that self-injurers prefer physical pain to emotional pain. We determined that 17.2% of participants denied pain during NSSI. Those who engage in self-injury seek to feel real by means of self-injury. For instance, Klonsky[42] asserts that certain people who self-injure occasionally do not feel pain or are in a state of dissociation. By injuring themselves, they feel a positive effect that allows them to escape from the emotional pain.[67]

In this study, the NSSI function with the highest score is the affect regulation function. According to Taylor et al.[68] emotion regulation is the most frequently determined function of NSSI, because self-injury can provide emotional relief thereby strengthening NSSI behaviour[69]. This is underpinned by research results[70] and consistent with the findings of studies that show that there is a significant relationship between emotion regulation and NSSI[18,19,71]. The function of self-punishment is the second reason after affect regulation. Several studies have identified the function of self-punishment as a form of self-directed anger to be a reason for self-injury[42,72]. Similarly, pain when undertaking NSSI is a form of self-punishment[73]. It is worth stating that in terms of using the self-punishment function, women and men exhibited no difference. The third highest function revealed differences between women and men. In relation to NSSI regarding women, more anti-suicide functions are demonstrated, while men tend to use the interpersonal boundaries functions. The anti-suicide function as part of this intrapersonal function describes the struggles of NSSI survivors to avoid suicide, although they harm themselves to feel better. We must remain vigilant because significant risks can occur as a result of impulsive acts when carrying out NSSI or poor judgment concerning the consequences of self-injury (suicide due to an "accident"). In contrast, men use the interpersonal boundaries function, which is part of the interpersonal function more.

In this study, most of the students committed self-injury when they were alone. Reinhardt et al.[73] also reported this phenomenon and stated that practically

90% of subjects answered "Yes" or "sometimes" in response to questions pertaining to carrying out NSSI when they were alone.

The majority (60.1%) did not inform anyone about their self-injury. This is in keeping with the study conducted by Rowe et al.[33] who recognised several factors that hinder seeking help due to fear of negative reactions from others including stigmatisation, fear of confidentiality being breached and fear of being regarded as attention seeking. Several students specified that they did not want other people to know about their self-injury behaviour because they wanted to keep it to themselves. Only a few try to find professional help (6.6%). If they ask for assistance, they notify informal sources such as family or friends. Several studies[33,36,74] have ascertained that friends and family are generally a source of social support. This is consistent with the findings of the study by Xin et al.[75] which asserts that social support can be a protective factor for preventing NSSI. As a consequence, those who receive more social support tend not to perform NSSI. In addition, it is worth noting that good quality friendships and low levels of loneliness can prevent NSSI.[76]

In line with other studies, the result shows that emotional ability is significantly associated with NSSI. In fact, most of the psychological problems associated with students are partly due to their poor ability to regulate emotions. Hence, it is imperative to develop training programs that improve the ability to regulate emotions so that students are able to develop appropriate strategies to reduce or avoid the problems they encounter. Likewise, if it is further observed that students with low economic levels are related to NSSI, it is important to prioritise intervention targets for them. It is important to mention that students with a low economic level encounter challenges in relation to accessing mental health service facilities, therefore there is an even more urgent need for the prevention and management of NSSI. In addition, the prevalence is relatively high and is associated with problems related to seeking help. Hence, it is necessary to design and implement a supportive program.

The limitation of this study is that it only uses a cross-sectional method which relies on self-reporting, making it difficult to obtain a more comprehensive representation. Thus, we cannot draw any causal conclusions with these cross-sectional and correlational methods. The finding needs to be confirmed by applying other criteria and employing a further questionnaire to gauge whether it would be beneficial to undertake further research pertaining to NSSI. This study has only examined this disturbing phenomenon and has not connected it with other factors that may possibly be risk factors or protective factors.

CONCLUSION

This prevalence of NSSI in student findings indicates that NSSI is still a public health issue in Indonesia. Nonetheless, it can be difficult to rate conclusively. The majority of NSSI students did not have help-seeking behaviour. Most of them are afraid of other people's negative reactions and fear being thought of as attention seeking. Meanwhile, this NSSI action is performed in order to achieve an unrestrained emotional state. Thus, it is critical to follow up with prevention and management need a social environment to assist NSSI students in developing approaches that enable them to deal with challenging issues by way of applying appropriate emotional communication skills and avoiding risky behaviour.

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