

Traumatic Childhood Experience and Self-harm Behaviour in Adolescent: A Review

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ABSTRACT

The rate of self-harm in adolescents is increasing and therefore has become a wide-spread public health problem. According to a meta-analytic study done in 2018, the lifetime prevalence of self-harm is 16.9% with the average age of starting self-harm was 13 years, and adolescents who self-harm also have a significantly higher risk of suicidal ideations and attempts. This paper reviews studies related to traumatic childhood experience and its relations to self-harm behaviour in adolescent. Several topics are discussed in more details, i.e. traumatic childhood and self-harm behaviour in adolescent themselves, roles of traumatic childhood experience in the development of suicidality, understanding the psychopathology of self-harm and traumatic childhood experiences, emotion dysregulation as a mechanism, possible mediators, preventing self-harm behaviour in adolescent with traumatic childhood experience, and the Islamic inputs on the topic discussed. This information may help to early detect and rapidly recognize those who experienced childhood trauma as a specific group at risk for NSSI and suicidal behaviours. Therefore, we recommend that higher risk group such as adolescents that has a history of any form of childhood trauma should be given the necessary intervention before possibly engaging in any self-harm behaviour. Future research should explore systematically the role of vulnerability and protective factors, i.e., factors that may act to increase or attenuate, respectively, the association between childhood trauma and NSSI.

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1. Introduction

The rate of self harm in adolescents is increasing and therefore has become a wide-spread public health problem (Patalay & Gage, 2019). According to a meta-analytic study done in 2018, the lifetime prevalence of self-harm is 16.9% with the average age of starting self-harm was 13 years, and adolescents who self-harm also have a significantly higher risk of suicidal ideations and attempts (Gillies et al., 2018).

Adolescence is a highly sensitive period for the onset of self-harming behaviors, such as disturbed eating behaviors and suicidal thoughts and behaviors, which can have a devastating impact on adolescents' lives (Nock et al., 2013; Pearson et al., 2017). According to Dube et al (2001), one of the important vulnerability factors in the development of self-harming behaviors is childhood traumatic experiences. Furthermore, the behaviors of self-harming have also been linked to developmental processes such as identity formation. Studies showed that identity has been found to

play an important role in the association between trauma and self-harming behaviors in Western studies (Klimstra & Denissen, 2017).

Suicidal thoughts and behaviors are examples of related prevalent self-harming among adolescents. Statistics showed that the cases are high. According to Noct et al (2013), in Western countries, estimated lifetime prevalence rates of suicide ideation, plans, and attempts are respectively 12.1%, 4.0%, and 4.1% in adolescents. Meanwhile, according to Mortlier et al (2018), the average age of onset for suicidal thoughts and behaviors has been found to be between 14 and 15 years in both Western and non-Western countries. Hence, developmental factors in adolescence should be taken into account as possible underlying mechanisms in the vulnerability to suicidal thoughts and behaviors.

While looking into different literature on the topic of self-harm, there are usually two types of ways of defining self-harm. One is called 'deliberate self-harm' and it is defined as when a person is deliberately and directly harming their body regardless of the intent of suicide (National Institute for Health and Care Excellence [NICE], 2013). The other type is when the behaviour of self-harm is done without suicidal intent also known as non-suicidal self-injury (NSSI) which includes behaviour such as cutting, biting and burning the skin (Zetterqvist, 2015). The current study focuses on the latter forms of self-injurious behaviors but does not distinguish between behaviors based on the presence or absence of suicidal intent. Therefore, both the self-harm and NSSI research traditions are relevant here.

Traumatic experiences such as sexual abuse, physical abuse, emotional abuse, and neglect during childhood is one of the well established risk factors of self-harm. According to Nock et al. (2013) and Smyth et al. (2008), traumatic experiences have been recognized to play a crucial role in the development of self-harming behaviors. In many cases, self-harming behaviors can function as a way to escape from the overwhelming and negative feelings related to trauma, when more adaptive coping strategies are unavailable (Gurung, 2018).

Childhood trauma can be categorized into Neglect is when a caregiver refuse to give the appropriate care that is needed for the child's age (Dubowitz, 2016) furthermore, a lot of these cases are due to the It can be There are . Eventhough the cause of this is unclear, self-harm may be used as a coping mechanism to deal with distressing emotions (Peh et al., 2017). The psychological and physical development of a child is crucial

A cohort study done by (Paul & Ortin, 2018) showed that neglect which is a subtype of childhood trauma was the only childhood trauma that independently predicted self-harm. According to Chen et al (2019), it is important to observe this as self-harm is one of the strong predictors of suicidal death. This paper reviews the traumatic childhood experience and its relation to self-harm behaviour in adolescent.

2. Traumatic childhood

Childhood trauma is an event experienced by a child that evokes fear and is commonly violent, dangerous, or life-threatening (De Bellis and Zisk, 2014). Also sometimes referred to as adverse childhood experiences or ACEs, there are many different experiences that can lead to trauma.

Physical or sexual abuse, for example, can be traumatic for children. One-time events like a car accident, natural disaster (like a hurricane), the loss of a loved one, or a major medical incident can take a psychological toll on children as well.

Ongoing stress, such as living in a dangerous neighborhood or being the target of bullying, can also be traumatic for a child—even if it just feels like daily life to an adult.⁵

According to Council on Communication and Media (2016), childhood trauma doesn't even have to involve experiences that occur directly to the child. Watching a loved one endure a major health issue, for instance, can be extremely traumatic for children. Violent media can have this effect too

2.1. Impacts of Childhood Trauma

Traumatic events can affect how a child's brain develops, which can have lifelong consequences for them physically, mentally, and socially (Glibert et al., 2015).

2.1.1 Physical Health Impacts

When a child experiences a traumatic event, it can impair their physical development. The stress can impair the development of their immune and central nervous systems, making it harder to achieve their full potential.

A 2015 study published in the American Journal of Preventive Medicine reports that the more adverse experiences a child has, the higher their risk of chronic disease later in life. Specifically, it notes that exposure to repeated trauma increases a child's risk of developing:

- Asthma
- Coronary heart disease
- Diabetes
- Stroke

A 2019 review of 134 different research-based articles adds that exposure to adverse experiences as children increases the risk of developing several different conditions—such as autoimmune diseases, pulmonary disease, cardiovascular disease, and cancer—in adulthood, as well as increasing levels of pain. (Zarse et al. 2019).

2.1.2. Mental Health Impacts

According to Gilbert et al (2015), childhood trauma can also have an impact on mental health. Psychological effects of traumatic experiences can include:

- Anger control issues
- Depression
- Emotional distress
- High levels of stress
- Post-traumatic stress disorder (PTSD)
- Psychotic disorders

Children exposed to complex traumas may even become disassociated. Dissociation involves separating themselves from the experience mentally. They might imagine that they are outside of their bodies and watching it from somewhere else or they may lose memory of the experience, resulting in memory gaps.

Research published in Psychiatric Times further notes that the prevalence of suicide attempts is significantly higher in adults who experienced traumas such as physical abuse, sexual abuse, and parental domestic violence as a child (Wagner, 2016)

2.1.3. Relationship Impacts

A child's relationship with their caregivers—whether they be parents, grandparents, or other familial or non-familial adults—is vital to their emotional and physical health. The attachment children have with their caregivers can help them learn to trust others, manage emotions, and positively interact with the world around them.

When a child experiences a trauma that teaches them that they cannot trust or rely on that caregiver, however, they're likely to believe that the world around them is a scary place and people are dangerous. This lesson makes it incredibly difficult to form relationships throughout their childhood and into their adult years (Huh, et al., 2014).

Children who experience trauma are also likely to struggle with romantic relationships in adulthood. A 2017 study in the Journal of Family Psychology found that spouses with a history of child abuse tend to have less satisfying marriages, even when still in the newlywed phase (Nguyen et al, 2017)

2.1.4 Other Impacts

Sometimes the impact of childhood trauma extends beyond physical or mental health and relationships. For instance, some studies have connected adverse childhood experiences with an increased risk of becoming a criminal offender by the age of 35, oftentimes committing offenses that are serious and violent (Nguyen et al, 2017)

Additional impacts can include:

- Being easily "set off" and having more intense reactions
- Engaging in high-risk behaviors (such as driving at high speeds or unsafe sex)
- Inability to plan ahead or prepare for the future
- Increased risk of self-harm
- Lack of impulse control
- Low self-esteem
- Trouble problem-solving or reasoning
- Children experiencing traumatic events may also have a reduced ability to parent their own kids later in life.

3. Self-harm Behaviour in Adolescent

The exact prevalence of self-harm rates varies due to difference in definition applied, assessments and different ways of measurements (Kokkevi et al., 2012). Despite these methodological differences, it is undoubtedly known that self-harm behaviour in adolescent is a huge problem with a community survey showed that one in five young adolescents reported thoughts of self-harm and one in ten engaged in at least one act of self-harm over a six month period, with the rates being significantly higher in females (Paul et al., 2013). On top of that, about half of adolescents who engages in self-harm will do it more than once, with the main methods used are overdose and cutting (Morey et al., 2008; Madge et al., 2008). Nonetheless, the presence of association between thoughts of self-harm and NSSI in both community (Kokkevi et al., 2012) and clinical groups (Asarnow et al., 2011; Wilkinson et al., 2011) is high.

There are a few factors associated with self-harm behaviour in adolescents that has been identified across multiple cross-sectional studies. It is found to be linked with the female gender (Kokkevi et al., 2012; Morey et al., 2008), girls with low esteems, experienced being bullied and knowing a friend who engaged in self-harm behaviours (McMahon et al., 2010). Other identified risk factors found across longitudinal studies include anxiety-related psychiatric problems (Thompson et al., 2005), depression (Haavisto et al., 2005; Moran et al., 2012) as well as substance misuse (Fergusson et al., 2000) such as cannabis (Moran et al., 2012). However, both parents living together is found as a supportive factor (Kidd et al., 2006; Sourander et al., 2006; Rissanen et al., 2009), although the exact list of protective factors is not known much.

As a preventive method, prevention programmes could be widely provided. Schools offer an accessible and convenient location for the delivery of self-harm prevention programmes— i.e. universally provided to all children as part of the school curriculum from the age of 12 years. In addition, mental health awareness needs to be raised so that issues such as low mood and self-harm can be openly discussed, local psychological services can be signposted, and access facilitated. Finally, specific advice on and skills to manage the potential risks of drug and cannabis use should be taught (Green et al, 2013).

4. Roles of Traumatic Childhood Experience in the Development of Suicidality

Childhood trauma also known as childhood maltreatment is recognized as an important risk factor in suicidal ideation, however it is not fully understood how the different types of childhood trauma influence suicidal ideation nor what variables mediate the relationship between childhood trauma and suicidal ideation.

Suicide is a multifactorial phenomenon with risk factors that includes psychosocial, neurobiological and psycho-pathological factors. It is recognized that childhood trauma can lead to suicidal ideation

and behavior. Although childhood trauma predicts suicidal ideation and behavior across the lifespan, the precise role of particular types of childhood trauma and the mediators of the relationship between childhood maltreatment and suicide have not been fully investigated (Figure 1) (Thompson et al., 2012; Miller et al., 2013).

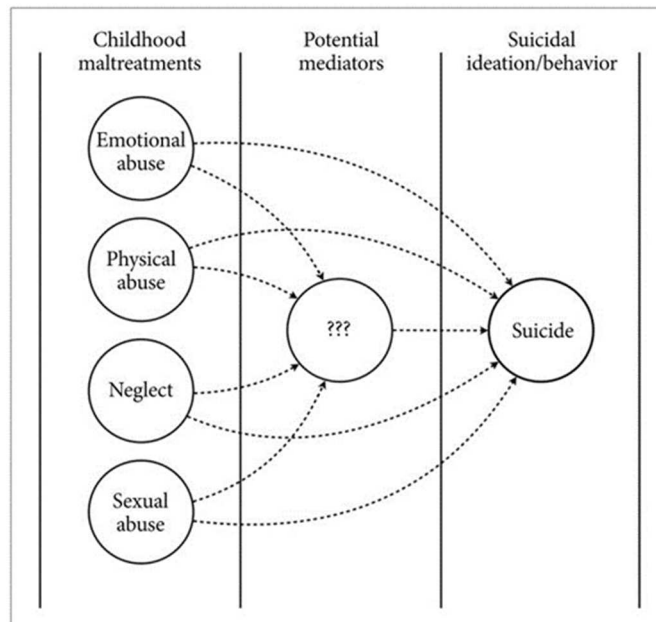


Figure 1. Relationship between childhood maltreatment and suicidal ideation and behaviour (Miller et al., 2013; Thomson et al., 2012)

There are few theories that has been suggested. Firstly, Bahk et al. (2017) examined the path from childhood trauma to suicidal ideation, including potential mediators. A sample of 211 healthy adults completed the Childhood Trauma Questionnaire (CTQ), Beck scale for Suicidal Ideation (BSI), Functional Social Support Questionnaire (FSSQ) and Hospital Anxiety and Depression Scale (HADS). Path analysis was used to investigate the relationship among study variables.

The results showed that of the several types of childhood maltreatment we considered, only childhood sexual abuse directly predicted suicidal ideation ($\beta=0.215$, $p=0.001$). Childhood physical abuse ($\beta=0.049$, 95% confidence interval: 0.011–0.109) and childhood emotional abuse ($\beta=0.042$, 95% confidence interval: 0.001–0.107) indirectly predicted suicidal ideation through their association with anxiety. Childhood neglect indirectly predicted suicidal ideation through association with perceived social support ($\beta=0.085$, 95% confidence interval: 0.041–0.154).

From this study it can be concluded that childhood sexual abuse is a strong predictor of suicidal ideation. Furthermore, perceived social support mediated the relationship between suicidal ideation and neglect. As well as anxiety fully mediated the relationship between suicidal ideation and both physical abuse and emotional abuse. The interventions that can be done to reduce suicidal ideation among survivors of childhood trauma should focus on anxiety symptoms and attempt to increase their social support, as shown in Figure 2.

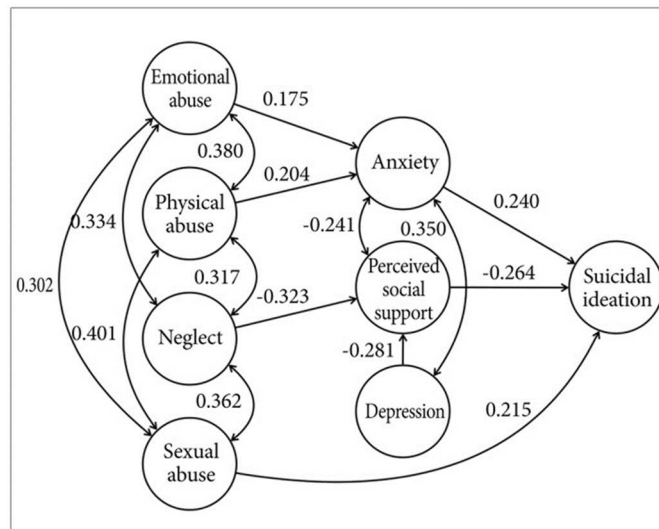


Figure 2. Trimmed Model (Bahk et al, 2017)

Corresponding to empirical findings, this theory have highlighted the role of traumatic childhood experience in the development of suicidality.

Another importance of this study is that the traumatic experiences that these children are experiencing have a larger impact on their developmental well-being earlier on in life rather than later on (Dunn et al., 2013). In their study, Dunn et al. (2013) reported that participants who were exposed to physical abuse, at any age, had a higher odds of depression and suicidal ideation in young adulthood than non-maltreated participants. The non treated participants, who were exposed during early childhood (ages 0-5), particularly preschool (ages 3-5), was most strongly associated with depression. Also, those who were first exposed during preschool to physical abuse had a 77% increase in the odds of depression and those first exposed during early childhood to sexual abuse had a 146% increase in the odds of suicidal ideation compared to respondents maltreated as adolescents.

This also highlights preventive measures that can be done as self-harm is a key risk factor for suicide as a follow up study done in hospital-presenting self-harm patients, 19% of those self-harm patients died by suicide in the study period between 2000 and 2010 (Hawton et al., 2015). The authors underlined the importance of prevention initiatives focused on the self-harm population, especially during the initial months following an episode of self-harm. Estimates using suicide and open verdicts may underestimate the true risk of suicide following self-harm. Thus, by identifying the high risks groups by taking a complete patient history can definitely help in the management of these patients. The main conclusions of the study may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section. Suggestion placed after the conclusion contains a recommendation on the research done or an input that can be used directly.

5. Understanding the Psychopathology of Self-Harm and Traumatic Childhood Experiences

Psychopathology is the scientific exploration of abnormal mental states that, for more than a century, has provided a clinical guide as well as scientific progress in modern psychiatry. In the era of immense technical advances, however, psychopathology has been increasingly marginalized by neurobiological, genetic, and neuropsychological research. This ongoing erosion of psychiatric phenomenology is further fostered by clinical casualness as well as pressured health care and research systems. The skill to precisely and carefully assess psychopathology in a qualified manner used to be a core attribute of mental health professionals, but today's curricula pay increasingly less attention to this and subsequently cause the border between pathology and variants of the "normal" further (Parnas et al., 2012).

Despite all prophecies that psychopathology was doomed, and with neurobiological parameters having yet to show their differential-diagnostic superiority and value for differential indication, psychiatric diagnosis continues to rely exclusively on psychopathology in DSM-5 and ICD-11. Their categorical systematic, however, is equally challenged, and, supported by advances in machine learning, a personalized symptom-based approach to precision psychiatry is increasingly advocated. The current paper reviews the objectives of psychopathology and the recent debate on the role of psychopathology in future precision psychiatry—from guiding neurobiological research by relating neurobiological changes to patients' experiences to giving a framework to the psychiatric encounter. It concludes that contemporary research and clinic in psychiatry do not need less but rather more differentiated psychopathologic approaches in order to develop approaches that integrate professional knowledge and patients' experience (Parnas et al., 2012).

In order to understand the etiologies of NSSI, previous studies have mentioned the one the gene-environment factors being one of the possibilities (Bresin et al., 2013; Hankin et al., 2015). Bresin et al. (2013) explored the interaction between retrospective reports of childhood emotional environment and the BDNF Val66Met polymorphism in relation to a history of two main types of self-injurious behaviors, suicide attempt and nonsuicidal self-injury (NSSI), in a sample of individuals with a history of involvement in the criminal justice system.

The finding of the study showed that for individuals with two Val alleles, there was a significant direct relationship between emotional maltreatment and self-injurious behaviors. However, the relationship was not significant for Met carriers. The study, however, had the limitation where the data are cross-sectional, which means causal inferences cannot be drawn.

From the study by Bresin et al. (2013) it can be concluded that the results indicate the possibility of a common etiological pathway for NSSI and suicide attempts.

Meanwhile, Hankin et al. (2015) investigated two independent samples of youth to test the a priori hypothesis that the Transporter-Linked Polymorphic Region (5-HTTLPR) that would interact with chronic interpersonal stress to predict NSSI. The authors tested this hypothesis with children and adolescents from United States public schools in two independent samples (N's=300 and 271) using identical procedures and methods. They were interviewed in person with the Self-Injurious Thoughts and Behaviors Interview to assess NSSI engagement and with the UCLA Chronic Stress Interview to assess interpersonal stress. Buccal cells were collected for genotyping of 5-HTTLPR. For both samples, ANOVAs revealed the hypothesized G*E. Specifically, short carriers who experienced severe interpersonal stress exhibited the highest level of NSSI engagement. Replicated across two independent samples, results provide the first demonstration that youth at high genetic susceptibility (5-HTTLPR) and high environmental exposure (chronic interpersonal stress) are at heightened risk for NSSI.

Again, there were only two empirical studies done which both only focused on single locus genes that affect the relationship between traumatic childhood experiences and NSSI. The first one is a study done by (Bresin et al., 2013) in which the found that Val66Met polymorphism i.a a mediating gene. As well as the second study done by Hankin et al., (2015) 5-HTTLPR gene polymorphism being the mediating gene.

Little is known on the effects of genetic factors between NSSI and traumatic childhood experiences. One of the studies have proposed that on top of the traumatic childhood experiences that these children were experiencing, the neurobiological factors are added on factors which increases the risk of suicidal behaviours such as DSH (Brodsky, 2016). The author reported that traumatic childhood experiencesqwa are associated with higher risk for suicide and suicidal behavior later in life. There are known associations between childhood trauma, particularly sexual abuse, and higher rates of suicide, non-lethal suicide attempts, and non-suicidal self-injurious behaviors in adolescence and adulthood. Emotional abuse/ neglect, disrupted parental attachment, and cumulative effect of multiple forms of maltreatment, also increase risk. Yet, the causal relationship remains unclear. The diathesis-stress model provides a framework for understanding how early life adverse experiences contribute to suicide vulnerability. His current findings from the fields of biology, neurology, and genetics shed new light on mediating variables and possible causal links between early childhood trauma and suicide (Brodsky, 2016).

However, studies have shown that to produce a psychological impact, multiple variants of genes work together instead of in isolation. The first study done on gene-gene environment interaction and NSSI is by (Gao et al., 2021) whereby they took saliva sample amongst Chinese male adolescents with traumatic childhood experiences and NSSI, and interestingly found that male adolescents that carries the genetic factors of MAOA G allele, MAOA T allele, or COMT Val/Val genotype are more susceptible to child abuse and NSSI which supports the theory of genetic role in adolescent NSSI.

6. Emotion Dysregulation as A Mechanism

One factor determining the link between traumatic childhood experience and self-harm behaviour in adolescents is maladaptive emotional regulation strategies (Haid-Stecher & Sevecke, 2019); one of the main theories on the cause is the emotion dysregulation pathway theory. According to empirical studies, the pathway mechanism of this theory varies, nonetheless, they all conclude that people who participate in NSSI have unbalanced emotions and this behaviour serves as an outlet to regulate their emotions (Fox et al., 2015).

A study done by Peh et al. (2017) hypothesized that the emotion dysregulation is a mediator between the severity of maltreatment exposure and self-harm, while controlling for depressive symptoms. In a study done amongst inpatients psychiatric adolescents by Haid-Stecher and Sevecke (2019) found that adolescents who engage in NSSI undergo emotion dysregulation more than those who don't engage in NSSI. This study also noted that these adolescents that participate in NSSI had gone through traumatic childhood experience, specifically childhood emotional abuse and neglect (Haid-Stecher & Sevecke, 2019).

Since the children that grew up in an emotionally abusive and/or neglectful caregiving environment usually don't have their emotional needs taken care of, they are not capable of recognizing their emotions and how to deal with them properly. Additionally the caregivers that neglect and emotionally abuse these children were supposed to be the ones protecting them and fulfilling their emotional needs. Therefore, these children will start having a negative perception of one's self, feeling undeserving of care and also self-hatred, doubt and disgust (Lang & Sharma-Patel, 2011; Yates, 2009). When these children that turn into adolescents face any overwhelming situations that make them react negatively, the automated response will be self-loathe. They will feel as -if they are unworthy and may use self-harm as a way to punish themselves, to distract them from the ongoing problems, to feel as if they regain control and as an emotional avoidance mechanism (Ford & Gómez, 2015; Lang & Sharma-Patel, 2011). This concludes that self-harm is a method of coping with emotion dysregulation corresponding to traumatic childhood experiences.

7. Possible Mediators

7.1. Dissociation as a Mediator

Traumatic childhood experience is an identified risk factor for Non-Suicidal Self-Injury (NSSI). Brown et al. (2018) investigated effects of different types of maltreatment, and mediating effects of depression and anxiety on NSSI in the general population. In their study, a representative sample of the German population, comprising N = 2498 participants (mean age = 48.4 years (SD = 18.2), 53.3% female). Child maltreatment was assessed using the Childhood Trauma Questionnaire (CTQ), NSSI was assessed with a question on lifetime engagement in NSSI, depressive symptoms were assessed by the Patient Health Questionnaire (PHQ-2) and anxiety symptoms by the General Anxiety Disorder questionnaire (GAD-2).

Results showed that lifetime prevalence of NSSI in this sample was 3.3, and 30.8% reported at least one type of childhood trauma. Participants in the NSSI group reported significantly more experiences of child maltreatment. Emotional abuse was endorsed by 72% of all participants with NSSI. A path analytic model demonstrated an unmediated direct effect of emotional neglect, a partially mediated effect of emotional abuse, and a fully mediated effect of sexual abuse and physical neglect by depression and anxiety on NSSI. It can be concluded that especially emotional neglect and abuse seem to play a role in the etiology of NSSI above and beyond depression and anxiety, while sexual and physical abuse seem to have a rather indirect effect (Brown et al., 2018).

To conclude, dissociative occurrences are likely to increase if a child experiences childhood neglect as it has the potential to hinder with identity development, and interfere with interpersonal relationships which will lead to DSH as a form of coping (Bourvis et al., 2017).

7.2. Self-identity as a Mediator

The critical time for a person developing their identity is during the adolescents period. Identity is defined by Erikson (1968) as the subjective feeling of uniformity throughout a period of time. Whereas identity confusion is defined as the aimless "mixed up" feeling and not having the ability to adhere to individual life commitments (Schwartz et. al 2009). As there are considerable amount of studies showing that NSSI is linked to identity confusion, this leads to several studies hypothesizes that childhood trauma with subsequent self-harm during adolescence is also contributed by identity confusion. One of the factors that has been positively linked to identity confusion is childhood emotional abuse (Bigras et al., 2015; Briere et al., 2017). Furthermore, a study by Kapeleris et al. (2011) showed that childhood emotional abuse has proven to give long term negative effects on self-identity. In a recent study, (Gu et al., 2020) has proven that identity confusion is an associated mediator between childhood emotional abuse and NSSI.

8. Preventing Self-harm Behaviour in Adolescent with Traumatic Childhood Experience

An adolescent's perception of self-harm plays a role in the cessation of self-harm. A study done amongst adolescents who self-harm by Deliberto and Nock (2008) found that the most common reason for them to stop engaging in self-harm is the awareness of knowing that self-harm is an unhealthy behaviour. Other participants in this study reported that the cessation is caused by not wanting the attention by NSSI, feeling ashamed and not wanting body scarring due to NSSI (Deliberto & Nock, 2008).

In a study done by Rissanen et al. (2009), adolescents reported that three groups of people can be a help in NSSI; which are age mates (including peers and other adolescents who also self-harm); loved ones and adults (including teachers, healthworkers, caregivers and unknown adults). Knowing that adolescents who grew up with traumatic childhood experience might not be able to seek help from their caregivers, other line of help should be attempted for preventive measures. We should also encourage awareness for teachers and healthcare workers on the topic of self-harm behaviours and how to recognize one, as they are the secondary line of help for these adolescents. It is important to remember that these adolescents with traumatic childhood experiences are less likely to receive family support, which is an essential factor in self-harm cessation (Tatnell et al., 2014) so other methods of prevention should be done.

Interestingly, while others might think engaging in therapy would help these adolescents in cessations, a study by Tatnell et al. (2014) actually showed that what helps instead is the perception of adolescents in the view of therapy. Having an open mind on therapy and the positive mindset of the outcome of therapy should be promoted to them.

9. Islamic Input on the Topic Discussed

A really important hadith that the Muslim patients with the cases being discussed in this paper can remember is the five before five hadith which is "Take benefit of five before five: your youth before your old age, your health before your sickness, your wealth before your poverty, your free time before you are preoccupied and your life before your death." (Al-Hakim).

Our Prophet Muhammad (صلى الله عليه وسلم) loves his followers so much that he gave us many pieces of advice to make our lives more fulfilling and devoted to Allah. From among his advice to us is to get

9.1. The Benefit of Five Before Five:

- Youth before old age: Young people have a lot of energy to worship Allah (SWT), perform our daily responsibilities, and enjoy our lives. But sometimes, many young people waste their youth

on distractions that do not benefit them. Hence, taking advantage of our youth with meaningful tasks is important.

- Health before sickness: Only when we are healthy, we can perform our acts of worship to Allah (SWT) with ease. Fasting the whole day and then praying Taraweeh at night during Ramadan are more easily accomplished when we are in full health. That's why it's crucial to maintain our health and not take it for granted.
- Wealth before poverty: Wealth in our religion is not only referring to the amount of money we own, but includes the blessings we have in our day to day lives, like our homes, cars, food, clothing, etc. Sharing even a small amount of our wealth can go a long way for those with little. Free time before preoccupation. Time is a valuable resource that we often take for granted. While we casually breathe at this very moment, someone else is taking their last breath.
- Life before death: No one has a guarantee of how long they will live, so it is important to always behave in a manner that pleases Allah with the mindset that we may die at any time.

9.2. Trust in Allah

Allah S.W.T mentioned in the Quran:

“And will provide for him from where he does not expect. And whoever relies upon Allah - then He is sufficient for him. Indeed, Allah will accomplish His purpose. Allah has already set for everything a [decreed] extent.” (Surah at-Talaq, verse 3)

Whatever hardships a person may be facing, it is important to have trust in the Creator as He is of more than enough help for that person as long as you have faith in Him.

9.3. Trial and Rewards

In Islam, the greater the hardship, or trial or tribulation the greater the reward. The greater the difficulty the greater the reward. The greater the trial or tribulation or difficulty that you are put through, the greater the reward will be given from Allah. If Allah loves someone, He puts them to trial, He tests them and places them in difficulty as mentioned in Surah Baqarah verse 155:

“We will test you with something of fear, and hunger and loss of wealth, and souls and vegetation. And give glad tidings to those who have patience. Those who if in any difficulty or trial, or tribulation occurs to them or happens to them, they say: ‘Verily We are from Allah and to Allah we return.’ They are those who will receive prayers from their Lord and Mercy and it is those who are guided.”

With regards to this cases discussed in this topic, we can say that the great reward is in accordance to how great ones trial, difficulty or test is. The greater the test and trial, the greater the reward. And everyone must have tests and everyone will have problems and trials and everyone will be put to difficulty, everyone will have moments of grief, moments of sadness moments when things are not as they feel or would like them to be. But the difference is the believer is patient, the believer believes in the decree of Allaah, the believer seeks the reward of Allaah (subhana wa ta'ala) at that time.

As recorded in Buhari and Muslim: The Prophet SAW said :

“Whoever Allah wants good for him, he puts them to test. He puts them through difficulties. Like a diamond or some metal that has to be burnt and then that which is bad from it is removed so that you have that which is the pure diamond or the pure gold or whatever. Put them to tests, trials and difficulties.”

We can take the stories of the Prophets for example, the ones who received the most difficulty, and went through the most hardship were the beloved people to Allah: the prophets. Allah loved them more than the rest of mankind or creatures. He tested them. He put them through test , he put them through hardship, he put them through difficulties. As-Sabr, patience upon when you are put to trial, upon when you are put to test, upon when you go through sadness, upon when you go through hardship, upon when you go through difficulties. Patience is a sign that you are upon Khair. It is the sign that you are upon good. It is a distinguishing characteristic, or it is a distinguishing matter that shows that you are upon good.

Tests, trials, difficulties, hardships, grief, sadness, pain it raises the level of the believer. It raises the level of the believer. It is an expiation for sins. It removes sins, these difficulties and it raises one's

level higher with Allah. Raises one's level higher, places one in His station or circumstance that he might not have met, he would never have reached if he had not gone through that test.

10. Conclusion

In conclusion, this information may help to early detect and rapidly recognize those who is experiencing childhood trauma as a specific group at risk for NSSI and suicidal behaviors. Therefore, we recommend that higher risk group such as adolescents that has a history of any form of childhood trauma should be given the necessary intervention before possibly engaging in any self harm behaviour. Future research should explore systematically the role of vulnerability and protective factors— i.e., factors that may act to increase or attenuate, respectively, the association between childhood trauma and NSSI.

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