

## **Self-Harm and Suicide Amongst Children and Young People**

**A Research Report**

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Commissioned as part of a multi-phase workforce development and research project for Knowsley Self Harm and Suicide amongst Young People Working Group.

Commissioned by NHS Mersey (on behalf of Knowsley Clinical Commissioning Group) in order to support the delivery of the Knowsley Emotional Well-being Strategy.

## **Acknowledgements**

I would like to thank my colleague, Annmarie Grealish, for her help with the data analysis and her contribution to this report. I would also like to thank all those who participated, directly and indirectly in the study, by graciously giving their time to meet with me to discuss the study. Lastly, and most importantly, I would like to thank the participants for their courage in sharing their personal experiences with me.

Contents	Page
Introduction	4
Literature Review	7
Methodology	16
Findings	23
<i>Fiona's Story</i>	24
<i>Lorna's Story</i>	29
<i>Kim's Story</i>	31
<i>Tina's Story</i>	34
<i>Julie's Story</i>	37
<i>Nina's Story</i>	40
<i>Lizzie's Story</i>	44
<i>Linda's Story</i>	48
<i>Valerie's Story</i>	52
<i>Jean's Story</i>	57
<i>Across All Young people's Narratives</i>	59
<i>Across All Adult Narrative</i>	70
Discussion	77
Limitations	80
Conclusion	81
Recommendations	82
References	83
Appendices	88

## INTRODUCTION

Epidemiological studies show that there has been a global increase in the incidence of adolescent self-harm and suicide behaviour during the last decade (Scoliers et al., 2009). It is suggested that around two thirds of children and adolescents presenting with self-harm and suicide behaviour are likely to experience depressive disorders, whilst adolescents demonstrating suicidal intent, and who have chronic recurrent affective illness, are at increased risk of repeating the behaviour (Kerfoot, 1996; Harrington et al., 1998; Spirito et al., 2003; Green et al., 2011). While many studies have focused on those who attended Accident & Emergency (A & E) departments following acts of self-harm, community studies show that large numbers of adolescents using such behaviour do not receive or seek out medical attention (Hawton et al., 2002; Madge et al., 2011). With regard to suicidal intent, a number of studies using a range of data collection methods, agree that the one common motivation is that of intrapersonal reasons, for example young people verbalising 'I wanted to die', 'I wanted to punish myself', 'I wanted to escape from a situation I found unbearable' (Skoogman, 2003; Holden & Delisle, 2006; Scoliers et al., 2009).

During the past 15 years there has been growing commitment to listening to the views of children, young people and their parents/guardians regarding their mental health needs (Buston, 2002; Fallon et al., 2012; McAndrew et al., 2012). The importance of consulting children and young people is a central tenet of the United Nations Convention on the Rights of the Child (1989), a policy the UK made a commitment to in 1991. Article 12 states the need to seek and take into account children's wishes when making decisions about their welfare (Children's Rights Development Unit, 1992). With regard to mental health, studies undertaken to specifically explore the views of young service users and their carers have predominately related to Child and Adolescent Mental Health Services (CAMHS) or more generalist services that address mental health and mental wellbeing. However, the Audit Commission (1999) reported that only 35% of Health Authorities consulted children and parents regarding their needs in terms of specialist mental health services, namely CAMHS, and even then, some had not used the results to inform service development.

Many of the studies available examining issues of self-harm and suicide have explored the underlying reasons for the behaviour and the implications for services (Dow, 2004; Mental Health Foundation, 2006; Dimmock et al., 2011). Only a limited number of studies have focused on service provision from a service user and/or carer perspective, and many of these studies are either retrospective or present the views of adult service users rather than the experiences of young people (Palmer et al., 2007; Tatiana et al., 2009).

With regard to services available to young people and guardians of young people who self-harm, only 2 studies have reports on barriers to help seeking for self-harm from an adolescent perspective (Storey et al., 2005; Fortune et al., 2008). Likewise, regarding parents of young people who experience self-harm and suicide behaviour, a study undertaken by Oldershaw et al. (2008) found that although parents often spot signs of self-harm early and therefore have opportunity to play a key role, they struggle to understand and cope with self-harm and its personal impact.

### **Local context**

At a local level, in 2011 the Knowsley Child Death Overview Panel identified concerns relating to suicide incidents and the rates of reported and un-reported self-harm for children and young people under the age of 18 living in the Knowsley area. The panel commissioned a needs assessment from the Knowsley Public Health team and the CAMHS commissioner, which was presented to the Child Death Overview Panel and to Knowsley Safeguarding Children Board. The local needs assessment confirmed that Knowsley has relatively low levels of reported self-harm (8<sup>th</sup> lowest across North West authorities for emergency admissions per 100,000 population for 2007/08 and 2009/10) and relatively low levels of suicide. Anecdotally however, practitioners across the children's workforce report high levels of identified or self-reported self-harm and between 2008 and 2012 there have been 4 suspected child suicides and one suspected suicide for a young adult in transition. In response to the report it was agreed that children's commissioning would establish a self-harm and suicide task and finish group.

In September 2011 the Self Harm & Suicide Working Group was established, with membership being extended to a wide range of partners who were working with Knowsley children in a variety of settings, community and acute hospital settings and beyond the borough's boundaries. The focus of the group was to evaluate current practice in self-harm and suicide prevention and support, with a view to making recommendations for future practice. Over a series of meetings and using a thematic approach, the group scoped out current issues and challenges and identified five areas for progress, one of which was:

- Giving voice: To undertake qualitative research to give voice to young people and guardians of young people who have experienced self-harm and suicide behaviour, the focus being on their experiences, with regard to use and/or non-use of statutory and non-statutory services.

In order to address this particular area, a research project, exploring the views of young people and parents/guardians of young people regarding their experiences of help and support for self-harm, was commissioned. It is anticipated that the findings from this project, in conjunction with an enterprise project that ran simultaneously, will help facilitate the development of a high risk self-harm and suicide pathway for professionals working with this group of people.

## REVIEWING THE LITERATURE

### Involving young people

The mental health of young people has been a growing concern of Western society (Moon et al., 1999; Irwin et al., 2002; Mental Health Foundation, 2006). In the UK, 1 in 5 young people experience mental health problems (Mental Health Foundation, 2006), with 1 in 4 of 5-15 year olds being referred to specialist mental health services (Meltzer et al., 1999). A rise in the rate of depression among young people and its link to suicide have prompted questions regarding resources and whether or not these are sufficient and available in the places they are most needed (Burns & Rapee, 2006).

Since the turn of the century the importance of involving children, young people and their parents/guardians in decisions regarding their health and social care needs, have been reiterated in a variety of policies. 'Learning to Listen', the principles for involving children in work in all government departments (CYPUP, 2001, DoH, 2002) and the National Service Framework (NSF) for Children, Young People and Maternity Services (2004) emphasised the importance of actively seeking out the views of very young children, young people, carers and others with regard to planning, improving and evaluating services. In addition, the NSF specifies a range of 'markers of good practice', including the involvement of service users in decision making, account being taken of their views with regard to commissioning strategies and there being a senior lead in each organisation to ensure that their needs are at the forefront of local planning and delivery (NSF, 2004). In order to achieve the goals of such policies a package of proposals was outlined in the Green Paper, 'Every Child Matters' (2003) and subsequently in the Children's Act (2005), calling for the integration of education, social care and some health services (Children's Trust, 2008). With regard to mental health services, it has been suggested that these would be more accessible in schools (Baruch, 2001; Hartley-Brewer, 2001).

Research has demonstrated that children are capable of reflecting on their experiences and able to make a contribution to decision making in complex and sophisticated ways (Dadds et al., 1998; Clark & Moss, 2001), however, a number of studies have highlighted how children and young people are often asked for their views, but not heard. McLaughlin (1999), in a small scale study with secondary school aged pupils, concluded that while they had a desire to be heard in school what they experienced was feelings of not being listened to. Likewise, a study conducted by Le Surf and Lynch (1999) with participants in their upper teens and early 20s found that they were not always listened to by adults; there was a fear that confidentiality would not be honoured; and the young male participants were particularly concerned about the social stigma attached to counselling. More recent studies report that

there has been no change of practice as a result of hearing children's and young people's views (Curtis et al., 2004; Worrall-Davis & Marino-Francis, 2008) with Neil (2005) emphasising the importance of acting on recommendations made by young people.

### **Search strategy**

To elicit existing papers relating to the perspectives of young people and guardians of young people who have experience of self-harm and suicide behaviour, the search was approached systematically. Terms used to describe self-harm and suicide behaviour and integrated medical subject heading (MeSH) (for example self-harm, attempted suicide, suicide ideation, suicidal feelings, suicide behaviour, borderline personality disorder) were listed and the synonyms searched both as free text and thesaurus terms. Using the terms generated, the following databases were searched: MEDLINE, a bibliographic database of life sciences and biomedical information; British Nursing Index (BNI), a bibliographic database that indexes articles from popular English language nursing journals primarily published in the UK; Cumulative Index to Nursing and Allied Health (CINAHL), a database that includes journal articles about nursing and allied health; PsychINFO, an abstract database providing systematic coverage of the psychological literature; and Applied Social Sciences Index and Abstracts (ASSIA), an indexing and abstracting tool that includes health, social care and other related disciplines. Websites for voluntary organisations were also searched, as was Google Scholar, the latter having comprehensive coverage for systematic reviews in health (Gehanno et al., 2013). In order to capture relevant studies the following inclusion criteria was used: papers written from the young person's and/or their carers perspective of mental health services, papers written in English and those published between 2000 and 2013. Duplicate studies were identified and the reference list of each paper that met the criteria was hand searched for further studies.

The results of the search showed that studies undertaken in the UK since the year 2000, written in English, and offering a young service user/carers perspective of mental health services equated to 4 qualitative studies (Buston, 2002; Roose & John, 2003; Hart et al., 2005; Curtis et al., 2005), 1 using survey to collect both quantitative and qualitative data (Fortune et al., 2008), 1 mixed methods study (Fox & Butler, 2007), 1 systematic review (Worrall-Davis & Marino-Francis, 2008) and 1 study that reported on the qualitative aspect of a larger study (Storey et al., 2005). Of the 8 studies identified, 4 focused on mental health services (Buston, 2002; Roose & John, 2003; Hart et al., 2005; Worrall-Davis & Marino-Francis, 2008) 1 on local health services (Curtis et al., 2005), 1 on counselling services in schools (Fox & Butler, 2007) and 2 on services accessed by young people who self-harmed (Storey et al., 2005; Fortune et al., 2008). Given the topic it is not surprising that most of the

studies are qualitative in nature. While this might have been problematic a few years ago, qualitative research and the role it plays in providing an evidence base to inform practice is now fully recognised by the NHS Centre for Reviews and Dissemination (2001). In the next section an overview of each of the 6 studies focusing on qualitative data (Buston, 2002; Roose & John, 2003; Curtis et al., 2005; Hart et al., 2005; Storey et al., 2005; Fortune et al., 2008) will be presented as to the methods they adopted and findings reported. These will be followed by the study using a mixed method approach (Fox & Butler, 2007) and finally a synopsis of the systematic review will be presented (Worrall-Davis & Marino-Francis, 2008)

## **Literature review**

The qualitative study undertaken by Buston (2002) focused on exploring the health-related views and experiences of adolescent users of mental health services. Buston (2002) used semi-structured interviews with 32, 14 – 20 year olds who had been diagnosed with mental illness a year or more previously, but were still in contact with services. This study was part of a larger study whereby data was collected using interviews, the 'Offer Self-Image Questionnaire' (Offer et al., 1992) and case notes. This particular paper only reports on data collected via interviews. Analysis of data was undertaken using a ground theory approach, that of coding, and also NUDIST, a computer package for aiding the analysis of qualitative data. Respondents were able to articulate both positive and negative experiences in relation to their mental health care. Overall the comments related to the doctor-patient relationship, the treatment they received, the health care system and the environment in which the services were situated. Buston (2002) concludes that mental health services need to listen and take account of young people's views about services if help-seeking behaviour, compliance and improved services are to be achieved. In particular the findings suggest that attention needs to be given to the development of empathic communication skills by those health professionals working with adolescents who experience mental health problems.

Roose and John (2003) used focus groups to investigate young children's understanding of mental health and to elicit their views on appropriate services for their age group. A total of 16 participants were accessed from 2 local primary schools and all were in year 6 (10 & 11 years old). The researchers used 2 focus groups to collect data and each group comprised of 8 boys and girls. Interpretive Phenomenological Analysis (IPA) was used to analyse the data as it was felt that this approach best allowed for retaining the children's language in the analytic process.

The study findings saw the emergence of 4 themes; (1) continuum of developing difficulties, (2) access to help and support; (3) ideal services for this age group and (4) gender. With regard to this report, findings relating to the latter 3 themes will be considered. Under the theme 'access and support', friends and family, the role of teachers, help lines and voluntary groups, the GP and counsellors and therapist were all reported on. Findings revealed that friends and family can help with everyday problems, for example school issues and bullying, but for family problems children require another source of help. Teachers were not considered a safe choice for accessing help due to reasons of confidentiality, teachers may tell other staff and/or the information could colour their perception of the child. Help lines and voluntary agencies, for example National Society for Prevention of Cruelty to Children (NSPCC), were spontaneously mentioned as a way of gaining support, with participants recognising them through television and magazine advertisements. However, the children expressed concern that you need to see who you are talking to, clarifying that 'talking over the phone is worse as you haven't got a clue what the person looks like' (Roose & John, 2003, p547). With regard to the role of the GP, participants had differing views with regard to being a source of help for emotional problems, one of the factors impacting on this being the depth of the relationship with their GP. Finally, in this theme counsellors and therapists were mentioned, with some participants being aware where their contact details could be found. Counsellors and therapist seemed an attractive option for talking about problems because of their face to face contact.

In relation to the third theme identified, 'ideal services for this age group', the participants were asked to design an organisation for children of their age and to identify what issues would be most important. A nearby location, staff who are welcoming and friendly, having professional experience and expertise were all reported as important factor when developing services. Also confidentiality featured highly in this section. In the final theme, 'gender', there was agreement in both focus groups that boys were more vulnerable to 'living up to a certain image' which makes it difficult for them to express feelings. It was reported that the participants were able to associate the inability to express feelings with future mental health problems (Roose & John, 2003). When concluding their study, Roose and John (2003) highlight the level of understanding demonstrated by the participants, and the ability of this age group to usefully contribute to discussion on service development.

Another qualitative study carried out by Curtis et al. (2005) used interviews, play techniques and a website as a means of data collection with children and young people aged between 4 – 19 years old. Of those participating 92 were recruited from a variety of community based organisations, for example, nursery school, care leavers, disabled, those in contact with the police, and 57 were recruited from clinical settings at 4 local hospitals, including hospital

wards and outpatient waiting rooms. The participants were made up of 72 girls and 77 boys, with over one third being from ethnic minority backgrounds. The researchers analysed the data which had been recorded and transcribed. Each of the researchers read the transcripts independently, looking for recurrent themes. Differing interpretations were resolved through discussion. While the findings are said to include young people emphasising the impact of communication and relationships with staff on their experiences of health services and how, children as young as 4 or 5 years old are able to contribute helpful comments regarding their experience, the paper focuses on their findings not being received as 'new' information by managers and clinicians. In acknowledging how their report was received by managers and clinicians the researchers raise an important question, 'If we have known for so long that the issues raised here are problems, why are we not acting on this knowledge?' While the researchers offer 4 possible explanations as to why this might be, it is based on speculation rather than empirical evidence.

Hart et al. (2005) undertook an exploratory study with 27 young people using CAMHS and their parents (30) to ascertain their views of the service. The study was particularly interested in the complexities inherent in CAMHS when parents are integral to treatment modes. The sample comprised of 11 boys and 16 girls. All the participants were white British from a range of socio-economic backgrounds. All participants were visited by the researcher/s at home prior to attending a focus group that used a range of structured interactive techniques to gather data. The paper does not specify how the qualitative data was analysed, but descriptive statistics were employed for some of the data gathered during the home visit and the focus groups. Three themes emerged from the study; the core values implicated in establishing a therapeutic alliance; the style of therapy; and mode of practice, its inclusiveness of different family members. The researchers' concluded that the process of eliciting these views was therapeutic in itself and led to the setting up of a parent-led self-help group.

Perhaps more pertinent to the research in this report is the study undertaken by Storey et al. (2005) focusing on young people's accounts of support they received for their self-harming behaviour. The study explored the views and experiences of a group of 74 young people aged 16-22 who repeatedly used self-harming behaviour. The participants were interviewed after attending A&E departments for intentionally harming themselves. The published paper focused on a sub-group of 38 young people having a history of self-harm behaviour starting prior to them being 16 years of age, and one-third of whom had, or were currently in care. The authors found that whilst some of the participants had kept their self-harming hidden and had not received any professional intervention until they reached adulthood, others had been in touch with services, although their treatment had not prevented them from

continuing to self-harm. Findings of the study suggest that medication was perceived as 'fobbing off', particularly when unaccompanied by other interventions. The young people described their encounters with counsellors and clinicians, some of whom they perceived not to understand or to listen to their perspective. The authors acknowledge that whilst their sample is not representative of all young people who self-harm, these views are important and deserve attention if interventions for children and adolescents are to prevent repetition of self-harm.

Finally Fortune et al., (2008) undertook a study specifically exploring sources of help and barriers to help-seeking before and after episodes of self-harm. A school based survey, using quantitative and qualitative data was distributed to 6,020, 15-16 year olds attending 41 secondary schools. Of those who took part 5,293 answered all the questions relating to deliberate self-harm (DSH). Thematic analysis was used for the open-ended questions. The findings from this study showed that the main source of support came from friends (40%), with few adolescents seeking help from formal services or health professionals. Barriers to seeking help included: self-harm being perceived as something that occurs on the spur of a moment and therefore not important enough to warrant serious consideration; the belief that they should be able to cope on their own and fear that seeking outside help might create more problems and hurt people they care about; being labelled as an 'attention seeker'; not knowing whom to ask for help; exposure to self-harm in the peer group and gender. In conclusion the authors suggest that in their study attitudes play a central role, the attitudes the young people have towards self, for example their ability to cope, and those of others, what people will think of them. In light of their findings the authors call for more effective community-based prevention and school-based programmes that promote psychological well-being (Fortune et al., 2008).

In a mixed methods study focusing on school counselling Fox and Butler (2007) sought young people's views on school counselling. The study was part of a national evaluation of the NSPCC Schools Teams, established as part of the NSPCC's 'Full Stop' campaign to end cruelty to children. The study took place in 5 secondary schools and involved a total of 415 pupils; 200 males & 215 females, with a mean age of 13.27 years. The researchers' targeted one class in each year group (year 7 to 11). Data were collected using a survey questionnaire, 9 focus groups and 16 face to face interviews with 16 young people who had used the counselling service. Of the sample, 92% had not accessed the counselling service and the researchers' acknowledge that the report, in the main, reflects the views of those who could only offer indirect experience of the service, but nonetheless are able to offer insight into reasons for not using the service. The questionnaire used open ended questions, apart from 2 questions, 1 requiring a yes/no answer and 1 that used a 5 point

scale. Content and statistical analysis was used to analyse the data (Fox & Butler, 2007). The top 4 reasons for accessing the school counselling service were: bullying, home issues; school issues; and risky behaviour. This supported previous evidence re family and peer relationships being the main causes of distress in primary and secondary school children (Hill, 1999).

The study findings suggested that whilst in the main young people valued the service, a substantial number (21%) lacked awareness of school counselling. For those who were aware of the service their knowledge was limited and it was felt that this could be due to it not being overtly advertised. With regard to using such a service, just over one third of participants said they would go and see a school counsellor, with girls more than boys having this inclination. Two main reasons for not accessing the counselling service emerged; the counsellor being a stranger; and, a particular concern for boys was the possibility of other people finding out and the attached stigma of being in receipt of counselling. In addition, confidentiality was also raised as an issue both as a benefit and as a hindrance factor, the concern being, as found in other studies, that it may not be confidential. (Howieson & Semple, 2000). Friends were also considered as another source of help, but a friend as confidant appeared ambiguous as it was felt they might not keep confidentiality, and they may not be best qualified to help.

In terms of improving the school counselling service a number of suggestions were made. One of main benefits identified was having someone to turn or talk to. This was similar to findings in Cooper's (2004) study, when evaluating counselling services in Glasgow schools. However, Fox and Butler (2007) found that talking to teachers was problematic, as this would imply a dual role. Indeed, the British Association of Counselling and Psychotherapy (BACP) advocate in their 'Guidance Booklet on Counselling in Schools' (2001) counsellors in school should not have dual role as boundaries become blurred. The participants believed that an advantage of having a school-based service was easy accessibility. At a more pragmatic level the young people articulated that if they were experiencing problems at home and the service was outside of the school it may well require their parent/s transporting them to attend for their appointment. Indirectly this relates to confidentiality and the practicalities of ensuring this is integral to the process. Direct access to school counsellors via post-box or drop-in was considered one way of achieving confidentiality. Participants also highlighted the need for advertising the confidential nature of the service and how this could be reiterated at the first session (Pope, 2002). A room in a discrete location, better promotion of services, more or a full time counsellor and ways of getting to know the counsellor better, for example through assembly, were all thought to be intrinsic to

promoting better use of the service. Fox and Butler's (2007) findings build on the earlier work of Le Surf and Lynch (1999).

A recent systematic review of the literature eliciting children's and young people's views of CAMHS was undertaken by Worrall-Davis and Marino-Francis (2008), the focus of which was to identify best practice. Systematic reviews are considered the top of the research hierarchy of evidence. Based on their inclusion criteria; studies written in English and children and young people up to the age of 18 expressed views of CAMHS, the researchers systematically searched electronic data bases and grey literature. For the purpose of their study 'CAMHS' was classified broadly to include, primary care (Tier1), specialist community and hospital based services (Tier 2 and 3) and day intensive outreach and in-patient services (Tier 4). Three outcome measure were used for assessing papers; (1) eliciting of true views as measured by inclusion of social desirability questions, (2) diverse views obtained, as measured by the presence of negative views about CAMHS, (3) changes to CAMHS delivery resulting from the views elicited, measure by changes reported in the study. In order to assess the quality of the studies the researchers used a framework commissioned by the Cabinet Office to guide policy-makers (Spencer et al., 2003). The framework involves the asking of 18 questions in order to assess the quality of the research. The systematic review generated 381 studies however, only 13 of these were appropriate for inclusion. The overall findings from the review were described as 'disappointing' in terms of the lack of change that had occurred as a result of research outcomes. While there are studies offering positive examples of successful change following dialogue with young people, for example school bullying (Tyler et al., 2006) diabetic clinics (Cairns & Brannen, 2005), Worrall-Davis and Marino-Francis recommend that prospective researchers check before undertaking research that their organisation is willing and able to implement changes suggested by the young people.

Each of these studies highlights the importance of not only listening to children and young people regarding their experiences and views of how services can better address their emotional and/or mental health issues, but also the need to take action. There appears to be a consensus that children and young people are able to offer age appropriate information, making a contribution to what services are needed and how such services can best be developed to meet their needs. Where and who is best placed to deliver these service is recognised within the research papers, as are the facilitators and barriers to young people accessing services that have been designed on their behalf. What is also interesting from reviewing the literature is the uniqueness of this project, in that regardless of self-harm among young people being an increasing global burden of the 21<sup>st</sup> century, there appears to

be no studies specifically looking at what services are needed from the perspective of young people and their main carer.

## **METHODOLOGY**

### **Research Question**

Self-harm and suicidal behaviour in Knowsley: What do young people and guardians of young people who self-harm and engage in suicidal behaviour think they need in terms of help and support?

### **Aim**

The aim of the study is to elicit detailed narratives of the experiences of young people and parents/guardians of young people who use self-harm and suicide behaviour in order to identify what they have found helpful and/or unhelpful and what they would like from a diverse range of statutory and non-statutory services.

### **Objectives**

1. To elicit, document and disseminate the narratives of young people who use self-harm and suicide behaviour with regard to services they choose or do not choose to engage with.
2. To elicit, document and disseminate the narratives of guardians of young people who use self-harm and suicide behaviour with regard to experiences of available services.
3. To ascertain what each of the above groups want from professionals and services to prevent the use of self-harm and suicide behaviour and improve their emotional wellbeing.
4. To draw on the findings to improve the multi-professional practice networks understanding and inform future practice in Knowsley.

### **Methodology**

Qualitative research that adopted an interpretive phenomenological analysis (IPA) approach was used when undertaking this study. Phenomenology aims to explore human experiences through detailed descriptions of the phenomenon being studied while seeking to understand how people experience and interpret their world (Creswell, 2003). Phenomenology also acknowledges the complexities of human experience, recognising the multiple realities constructed separately by each individual (Denzin & Lincoln, 1998). IPA is a research method that is particularly useful when working with children and young people and when wanting to explore the inter-subjective nature of experience such as emotional wellbeing and the mental health of young people (Lewis & Lindsey, 2003; Gale, 2007). Previously this

approach has been successfully used by the National Child and Adolescent Mental Health Support Service to explore children's' experiences of stigma and mental health, the process involving dual reflexivity with young people as participants actively shaping the research process and the researcher helping to mitigate against the power differentials that often occur in studies with young people as subject (Chistensen & James, 2000). IPA is idiopathic, valuing the importance of each individual narrative whilst recognising the contribution each makes towards a larger account from a small group of people (usually no more than 15) who share the experience of the phenomena being studied (Reid et al., 2005). Once this has been achieved IPA requires the researcher to interpret each nuanced story looking for similarities and differences across a group of participants (Brocki & Wearden, 2006). Using this method enabled the researcher to gain insight and understanding of young people and the guardians of young people who use self-harm and suicide behaviour on their help-seeking journeys and what has been or would be helpful when their mental health is compromised. The findings will be utilised to influence practice in Knowsley.

### **Recruitment of participants**

In keeping with the IPA guidance the aim was to recruit 10 young people, aged from 10-18 years who had experienced self-harm and suicide behaviour, and 10 adults who have or are carers for young people who have experienced self-harm and suicide behaviour. Participants were sought by way of posters advertising the study being placed at various organisations and on local internet sites that support the target group and/or given to clinicians who work with them. A number of posters were designed by young people who are members of SPARK, and of these, 2 posters were judged 'age appropriate best' (1 for under 11s (see appendix 1) and 1 for 11 and over (see appendix 2)) by a group of young people involved with the Youth Offending Service. Some of the organisations advertising the study were statutory services, some voluntary services, but posters were only displayed with the permission of those who have responsibility for the service. Participant invitation letters (appendix 3 & 4) and information sheets (appendix 5 & 6) were also left at each organisation so that staff working there could give them out to anyone who was interested in finding out more about the study. Potential participants were then able to contact the researcher directly or if preferred could do so via their parent and/or professional worker. All information was confidential. Where posters were given to clinicians they were accompanied by the appropriate invitation letters and information sheets and, if requested, the clinician could put them in contact with the researcher. Regardless of what path potential participants took to make contact with the researcher, further details of the study were provided verbally and opportunity given for the young person and/or the parent to ask and have answered any further questions and/or be sent more written information about the study to discuss with

anyone they wish. If an interest in taking part was expressed the researcher requested contact details (e.g. telephone number or email address) to contact the person within a week and ask if they had any further questions and if they would still like to participate. Despite attempts to recruit the number of participants stated above, difficulties were encountered. Reasons for this might reflect the topic being researched, in that it is a sensitive topic and having no previous contact or knowledge of the researcher may have impacted on recruitment. The number of people finally recruited to the study was 7 young people and 3 adults, 2 of them being mothers of 2 of the young people. Prior to being interviewed participants were asked to sign a consent form (appendix 7), for those under the age of 16 a consent form was signed by the participant and by their legal guardian (appendix 8) in accordance with the Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder: A guide for professionals (NIMHE, 2009). Two consent forms were provided to enable the participant to keep one copy and the other to be kept by the researcher. In accordance with guidelines for establishing Fraser Competency, the competency of all the young people under 16 to understand the information required for informed and voluntary consent was assessed by the researcher prior to commencement of the interview process. The researcher is appropriately qualified, experienced and skilled in undertaking such an assessment and in talking to children about emotional wellbeing issues. In keeping with British Psychological Society (BSP) (2010) guidance, the researcher used her skills to engage the young people in an age appropriate way and continuously monitor each young person's willingness to participate by observing their verbal and non-verbal signs of willingness to continue with the interview (BPS, 2010). All participants were informed that they would be able to terminate the interview at any time and their data would be destroyed and not used as part of the research. It was agreed by the steering group that each participant would be offered £20 worth of vouchers for W.H. Smiths.

## **Ethics**

Prior to the study commencing ethical approval was sought from the University of Salford and the NHS Health Research Authority, the National Research Ethics Service (NRES). In making both these applications guidance from the RCN Research Society (2011) and BPS (2010) was adhered to. Ethical approval was granted from the University of Salford in September 2012 (ref: HSCR 12/54) and from NRES (ref: 12/WM/0337) in November 2012.

The following was agreed with both above committees:

- All interview transcripts will be anonymised.

- It will be the researchers' responsibility to ensure no identifying information is used during the interviews.
- Following the completion of each interview the PI will listen to the recording to ensure no identifying material has been used. If any information is found it will be removed (taped over) before being sent to OUTSEC, an approved university transcribing service.
- Each participant will be allocated a pseudonym to enable transcripts and/or future outputs to be anonymised.
- The collection, storage and disposal of the data will be kept in accordance with the Data Protection Act (1998). Data stored electronically will be saved onto a password protected computer at the University of Salford, with only the research team having access to it.
- All signed consent forms will be stored by the PI in a locked filing cabinet in her office.
- Digital recordings will be deleted at the completion of the study.
- The exception to confidentiality will be the revealing of any illegal activities on the participants part, which the researcher, as a qualified mental health nurse, will be duty bound to report

As a number of participants would be under the age of 16 and they will be talking about a sensitive topic, additional strategies had to be put in place to ensure safety:

- With regard to age, all young people will be given the option of an adult being present when the interview takes place.
- Interviews will take place at a venue of their choice where they feel safe and able to talk.
- The researcher collecting data will have had an enhanced CRB check.
- Time will be allocated at the end of the interview (for both young people and adults) to discuss anything that they might have found distressing during the interview. This will not form part of the study and the audiotape will be switched off prior to this discussion.
- To address any subsequent distress experienced as a result of the interview there is agreement with all organisations providing services for these young people and parents of young people that psychological support and services will be made available. In addition, a 'KOOH' card, accessible online help for young people who are experiencing distress, will be given out at the end of the interview.

- For young people currently receiving treatment from secondary mental health services commitment has been given by the commissioning practice agencies to ensure appropriate aftercare is provided to these young people.

In addition, as financial and time constraints would not allow an increase in sample size, a strategy was put in place to address the event of more than 10 young people coming forward to participate in the research project. As the research was linked to a practice based workforce development project there was opportunity for young people to act as consultants for the purpose of improving practice. Any young person wishing to take part who could not be included in the research would be invited to contribute to the workforce development project via the practice steering and implementation group. However, given recruitment problems this was not necessary.

With regard to the researcher undertaking the 1:1 interviews the University of Salford's lone worker policy was adhered to, that is their location and time of interview will be known to another member of the project team.

## **Participants**

Regardless of attempts to recruit 10 young people and 10 parents/guardians of young people who have experienced self-harm and suicide behaviour, the number who volunteered to participate was 7 young people and 3 adults. All participants were females and white British, the latter being reflective of the population of Knowsley. The age of the young girls ranged from 13 – 17 years old. Of the 7 young people participating, 2 opted to be interviewed in their own home, 4 in school and 1 in college. With regard to the adults, 2 were the mothers of 2 of the young people and 1 was a foster parent, all 3 were interviewed in their own home.

In keeping with IPA the sample size is small. Smith et al (2009) recommends between five and 10 participants when using IPA as they argue that small number of participants allows for a richer depth of analysis that might be inhibited with a larger sample. However, there is a concern that small numbers of participants may not be representative of the wider population and equally that large sample sizes might prove to be too time-consuming and lengthy in terms of analysis. Smith et al., (2009) suggest that a rich account of participants' experiences that is related to the up to date literature, will allow application of findings to a wider population. In accordance with the recommendations for IPA, all efforts were made to ensure that the sample was homogenous (Quinn & Clare, 2008). For example in this

instance all young people participating had experience of self harm, all lived in the Knowsley area, and all had experienced a trauma and/or distress that had prompted their self-harming behaviour.

### **Data Collection**

Data was collected from a purposive sample, an approach that permits the researcher to intentionally select participants who have experienced the phenomenon under investigation (Parahoo, 1987). Narrative 1:1 interviews were undertaken with 7 young people and 3 parents/guardians of young people who have experience of self-harm and suicide behaviour and who have consented to participate in the study. Narrative interviewing enables participants to take control of what they share in terms of their world view, experiences and values with minimal interruptions from the researcher (Chistensen & James, 2000) Narratives are particularly important in health and social care research as the person/participant is central, facilitating understanding of what can often be complex and sensitive issues (Holloway & Freshwater, 2007).

The interviews took place at an agreed venue that felt comfortable for each of the participants and the researcher. Each interview lasted no longer than 45 minutes. Whilst demographic data was recorded by hand, the main part of the interview focusing on the participants' telling of their stories regarding self-harm and suicide behaviour and their experiences of services and/or what has hindered their accessing services was digitally recorded. During interview it was the researcher's responsibility to ensure that no information is used that would identify the participant. Transcripts were transcribed by OutSec, a confidential transcription service used regularly by the university.

### **Data Analysis**

The data from this study was analysed using 2 levels. In keeping with narrative interviewing and IPA principles the researcher analysed the transcripts, initially reading each as a whole story to ensure the essence of each narrative is captured. The method of IPA allows access to fuller and richer accounts of the participant's experiences and their understanding of self harm. To achieve this, the researcher read through each narrative line by line to ensure a more in-depth analysis (Smith & Osborn, 2008), again capturing themes emerging from each individual story. In addition, IPA requires that the researcher take care to minimize the risk of bias during analysis. This was achieved by the researcher being aware of their own experience, potential bias and the influence these may have on the analysis.

In using the main themes from each of the narratives a second analysis was then undertaken to identify similarities and differences across all of the narratives in each of the 2 groups (young people and adults). This was achieved by clustering the similar themes together under meaningful headings that utilised the participant's own words to ensure that the analysis remained close to the text and the participant's experiences. Following this level of analysis, the final themes were presented to a co-researcher who checked, modified and confirmed the themes to confirm the reliability of the analysis. An independent researcher then audited the initial descriptive and later interpretative analysis of the transcripts. Having an independent audit helps to ensure believability and credibility of the account produced. Findings from the data analysis are presented in the following chapter of this report.

## FINDINGS

In this chapter the findings from the above analysis will be presented. To reflect process of the analysis, the first set of findings will be presented in the form of narrative, a synopsis of each participant's story being presented to the reader. Following the narratives, findings will be presented in the form of themes across each group of participants, with direct quotes being used to demonstrate the believability and credibility of the analysis. All participants have been given pseudonyms in keeping with qualitative research that uses narrative as a means of data collection.

To aid the reader the following pseudonyms have been used:

Young person 1	Fiona	17 years	Linda	Fiona's mum
Young person 2	Lorna	13 years		
Young person 3	Kim	14 years		
Young person 4	Tina	14 years		
Young person 5	Julie	15 years		
Young person 6	Nina	17 years		
Young person 7	Lizzie	14 years	Valerie	Lizzie's mum

Jean is a foster parent who has looked after 2 boys who displayed self-harm and suicide behaviour.

Each participant was interviewed separately.

## **Fiona's Story**

*"it just came out and when it did it was....Phew, kind of you're just sad and relieved, and you just think, finally it is out there and now I know it is going to move forward and something is going to happen to help"*

Fiona is a 17 year old girl, who lives with her mother and father and older brother. She told me that she has been self-harming for approximately 12 months and that the behaviour was triggered by problems at school and her father's ill health. Her father has serious health problems as is often hospitalised. Fiona has had support from two services; Youth Offending Service (YOS) and Child and Adolescent Mental Health Service (CAMHS).

### **Self-harm and suicide**

Fiona said that by cutting herself she was able to get 'relief from her problems' that 'each cut was a relief from a problem'. Fiona felt 'overwhelmed by the problems at school and her dad's illness', for her, self-harm 'just slowed everything down', it 'allowed her time to think and put things into perspective'. Fiona described herself as a 'bad over-thinker' and explained how cutting 'just stops everything and you have a moment, just a peaceful moment'

Fiona told me that at a really low point she had thought about suicide. The low point came when she has been placed on a youth offending order, she is coping with exams, her father is seriously ill and she has to 'watch her mum being upset and struggling'. Fiona sees suicide as being 'an easy way out'. Fiona took herself off for a few hours and thought of suicide, but was rescued when a friend phoned her to find out where she was. She sat up all night talking to her friend and that was a 'relief'. After that one incident she went back to self-harming to 'steady out the balance', she describes this as 'self-harming, but still wanting to be here'.

There came a point when Fiona found that the self-harm 'was no longer helping'. She told me that it was 'something serious', 'a big part of her life' and therefore not something 'you can easily talk about'. She goes on to say 'you have to build up a relationship with people', 'build up trust'.

### **Trigger/s**

Fiona describes getting her YOS order as a way 'to blow off steam' at the pressure she felt she was under; 'exams', 'extra-curricular activities' and coming home having to help mum

with dad and seeing mum upset' was the trigger. Fiona said she realised how 'seriously stupid' it was getting in trouble that was 'against the law'. She talked about knowing that 'it was just going to get me into more trouble which got me more frustrated. So I think that's how I ended up turning to self-harm'. Fiona went on to tell me that she had 'noticed a lot of people do it', she had 'researched it on different web sites' and that she often saw the 'word relief' and that is what 'I needed'.

### **Previous experience of self-harm**

Fiona has friends who use self-harm. She tells me that when they told parents or friends some of the responses they got included 'why have you done that, it's stupid', that's idiotic', that's just attention seeking' all of which Fiona puts down to them 'not knowing the background'. She tells me about a poem that 'goes round on e-mail' describing 'self-harmers as over-emotional, getting upset and angry about the slightest thing'. Fiona goes on to explain that she thinks lots of people see 'self-harmers' in this way and that 'it's really hard to try and get out of this stereotyping'.

### **The route into services**

Fiona's route into services was via YOS, her YOS leader alerting the CAHMS person who worked with the team. Fiona describes CAHMS as 'Carers and Mental Health Services and denied knowledge of their existence prior to her YOS order. From committing the crime to being given a YOS order was approximately 3 weeks. Fiona was pleased it took such a short period of time as she was fearful of what would happen to her.

Fiona told me that she did not 'really want to talk to anyone' about her self-harming, as she did not 'feel comfortable discussing it'. Getting a YOS order meant she had to go and see 'her leader' every week and 'talk to her about personal things'. Fiona recalled that she did feel comfortable talking to her YOS leader as 'she wasn't going to be the kind of person who judged you' 'she wasn't going to be the kind of person to say anything bad'. Fiona said 'she'd be there to comfort me' 'she'd be there to get me the help and support that I needed'.

Fiona talked about 'finding the courage and the confidence to take that step and tell someone'. She told me how she 'did go into many meetings (with her YOS leader) wanting to tell her, but ended up not saying anything'. When Fiona finally did tell her leader she described there being a 'relief', 'it's finally happened, I can sit back and not worry as much because I know someone is going to help me'. Fiona tells me 'that a lot of people who self-harm or feel suicidal need that'. Fiona said she thinks that in total she has seen her YOS leader 'about 42 times before I finally got the confidence to get up and tell her'. She said that

her telling was prompted by the YOS leader telling her that 'you know you can tell me anything in confidence' (the YOS leader did add the caveat re disclosing anything about hurting self or others).

Fiona told me she had 8 sessions with the CAMHS worker who was male and described how they (CAMHS worker and herself) 'just sat and talked a lot'. Initially Fiona describes what could be an awkwardness between them. 'I didn't feel comfortable' and he said 'listen I've been trained in this sort of thing, I'm here to listen to you'. Fiona said she 'just sort of sat there and looked at him and thought, no you don't, you've not got a clue, your not going through what I am'. On their second session she said 'it had been a very bad week' and she 'didn't care who she told anymore'. Fiona said that 'knowing he was trained, that he wouldn't judge and no matter what she said he wouldn't run out of the room screaming or get mad' helped her open up. Fiona talked about his attitude, 'dead calm and collected', 'he was kind' and 'you could clearly see he was there to help'. His attitude made her realise that 'it wasn't necessarily talking to a stranger about my problems it was talking to someone who could help and that's the difference'. He asked her 'what she was thinking while she was doing it (self-harming), what she was feeling, what she felt afterwards and what she achieved'. She said that his relaxed manner and those questions set off thoughts about why she did it, was it worth it, and she attributes these thoughts to her stopping the self-harm.

### **Accessing help**

Fiona denied all knowledge of how to access support for her self-harm. She told me that 'it's not even a fact of wanting to tell someone, it's who do you tell?' 'Who do I turn to and where do I go and who's going to understand?' Fiona talked of nothing being 'publically advertised'. However, when I later asked her about the web sites she had accessed re self-harm she did say that there were 'links to support groups'. Fiona explained to me that at that point in time 'it wasn't a case of needing to go to a support group or phoning someone because I hadn't actually done anything'. Fiona then reflects on this and tells me 'just being able to ring someone and say listen I'm having thoughts of doing this, I think a lot of people wouldn't have self-harmed, if they could speak to someone before they self-harmed'. 'If I could speak to someone in confidence and comfort about what I was thinking, before I had actually done anything, then I probably wouldn't have self-harmed'.

When I asked about her GP she responded by saying 'your doctor is when you have a sprained ankle or when you have a cold, you don't think of your doctor as someone who you can go and talk to about self-harm'. 'I always thought that when it came down to stuff like self-harm or being suicidal, you didn't go to your GP'.

## **Family and Friends**

Fiona told her mum about the self-harm after she told her YOS leader. 'Because I told one person I kind of felt a bit more comfortable.' When telling me about telling her mum Fiona emphasises how self-harm is 'serious' and a 'big' thing. She goes on to explain 'I don't think she has ever had to deal with anything like that, so trying to explain something as serious or as big as that to someone who's never had to understand is really difficult'. Fiona talks of her mum being the 'hardest person' to tell as 'she was so close to me' and 'I knew that it would hurt her'. Fiona goes on to say that when she did tell her mum 'it did take her a few weeks to get her head round it', 'I did have to have numerous conversations' and 'I think to this day she doesn't understand it completely'.

Fiona's mum told her to explain it to her dad as 'she (her mum) had gone to him for support'. Fiona said that her dad 'didn't understand it either and so then I had to sit and explain everything to him as well as my brother'. Fiona believes that her parents had a right to know as they are responsible for her. She was indifferent about her brother knowing, he knew because 'he'd seen her scars' and been there when 'the CAMHS worker visited', but she has never had a conversation with him about it.

Fiona told me that she thought she 'didn't tell my friends, because I don't think my friends would have understood'. She went on to explain that now her and her friends are a bit older and understand more she has told them. She then talks about her friends (when younger) 'would not have known what to say or what to do' and they would have thought she was 'attention seeking'. Fiona also tells me she thinks she would have had a similar reaction to other people.

## **Past and Future**

Fiona talked about her lowest point 'it was kind of the fear of being alone, the fear of thinking I've got no one to turn to, I've got on-one who understands, and that was really big for me, what do I do, I'm on my own'. Fiona then tells me that '*if you know a support group is out there it makes it a little bit easier, so for me it's just getting the word out there, that they (support groups) are there to talk to and that they are there 365 days a year, 24/7*'. Fiona also talks of the need for people to talk about self-harm in assemblies in schools, giving information about why people self-harm and how talking to someone can help. Fiona believes that a better understanding about self-harm would make it easier for more young

people to talk to friends, saying 'for me it might have been that first step of talking to my friend that would have led to talking to someone else'.

When asked if she wanted to say anything else Fiona said

*"Just basically a thank you to for the organisations that are out there that do help, because without them God knows where I'd be. But you just need to get the word out a bit more"*

## **Lorna's Story**

Lorna is a 13 year old girl who lives with her adoptive mother and father. Lorna has 5 siblings none of whom live with her. Lorna started using self-harming behaviour approximately 6 months prior to being interviewed. Lorna told me that she started self-harming as a way of dealing with problems at school and at home. Lorna has had support from two counsellors from Social Services, one she sees at a clinic, the other at home. In addition, she is currently attending a dialectical behaviour therapy (DBT) skills group delivered in school by 'Kooth' and she gets support from two of her teachers.

This was a relatively short interview as Lorna found it difficult to talk about her experiences.

### **Route into services**

Lorna told me that it was her mum who initially took her to see the doctor and counsellors. The GP Lorna saw was female, but prior to going she was concerned that her GP '*might not understand*'. Lorna said that although she felt better after seeing her she was '*still unsure if she understood*'. When asked about the background of the counsellors Lorna was unsure, but thought they were from Social Services. Lorna told me that she had counselling in school on a weekly basis from September until Christmas. Lorna now has two counsellors; one, a male, she sees at a clinic and the other, a female, visits her at home. Lorna describes seeing the counsellor in clinic as '*better*' as her mum and dad go with her and '*they talk as a family*'. Lorna attends once a fortnight for these appointments. The other counsellor visits her at home approximately once a month and the focus is her self-harm, although she does say that they also talk about '*family problems*'. From what Lorna said it would appear that this counsellor sometimes talks to her with her mum present, sometimes on her own and her dad usually '*goes into the kitchen*'. Lorna describes both counsellors as '*nice, quite helpful*'. Lorna now also attends a DBT skills group delivered by Kooth, in school, for those who self-harm, but said little about the group, however, she did comment on two of her teachers who '*always ask if she is ok*' and I believe that she saw this as being a positive interaction for her.

### **Self-harm and suicide**

Lorna did tell me that she started to self-harm in response to being '*mocked at school*' as she is '*adopted*'. Lorna said she thought that '*it would make things better*' and she '*she has felt suicidal when things are really bad*'. At times when she feels '*really bad*' Lorna said she '*turns to her friend*', they have been friends since year 7, approximately 2 years.

Lorna struggled during the interview in terms of talking about her experiences. Some of the topics we discussed and her reactions to them, led me to think that there might be ongoing

family problems. Some of these problems were interrelated with the services Lorna is receiving and talking about them was too distressing. Lorna also found it difficult to articulate what help she thought she needed. I did not feel it was appropriate to continue with the interview and therefore brought it to a close.

## Kim's Story

*'The counsellors are very calm and I think that calms you. At the same time they are very understanding and they don't try to jump to conclusions. They are caring as well'.*

Kim is a 14 year old girl who lives with her mother and father and two siblings, her being the middle child. Kim started using self-harming behaviour approximately 12 months prior to being interviewed and this was triggered by problems at school and at home. Kim has 1:1 counselling in school and attends a Kooth DBT skills group delivered in school for people who self-harm. Kim has also been referred to CAMHS and at the time of interview was waiting to attend for her first appointment.

### **Suicide and self-harm**

Kim started using self-harm when she was 12.5 years old. The self-harming behaviour helped Kim to escape from problems at home and school. At times she has had suicidal thoughts and when these are in her mind she stays in her room *'to keep safe'*. But when we discussed Kim shutting herself away she told me that *'you feel more trapped'*. When talking about such times she reverts back to talking about the DBT skills group she attends saying, *'but if there's people you can speak to, that you know won't judge you because they do similar things, been in a similar situation and they know how it feels, then it's ok'*. Kim tells me that after she has self-harmed she *'feels bad about what I've done'*, *'ashamed'*. In clarifying this further Kim said *'when you're in that state of mind you don't really know who to turn to, because you don't want to be judged by people and that's a big part of it'*. Kim insists that *'being judged'* is what puts young people off seeking help.

### **Accessing help**

When asked if Kim had accessed any other services herself she said *'because I'm getting counselling I didn't find the need to get anymore, I'm not even sure there is any other services that I can reach out to'*. I then rephrase the question and this time Kim states *'I tried to [get help prior to her self-harming being discovered].....I built up the courage, but then when I got to it, it had diminished.....and then I started panicking'*. Kim told me that it was her older sister who she had intended to tell, but could not go through with it. She said *'I sort of put pressure on myself to do it and I pushed it, but then the pressure of actually doing it and I would have felt being judged by it.....and that added to it'*. Later in the interview I ask Kim what if things get bad during holiday time and she tells me she has thought about that since the Easter holidays are coming up. *I think maybe there are online support groups. I*

*was thinking if I feel down or feel that I may self-harm, then I'll go on because it's the time for support'.*

### **Route to services**

Kim had self-harmed at home, the results of which were seen by her younger sister. Her sister went and told her mum and dad, who *'rang the doctor for an emergency appointment'*. Kim goes on to say *'it all happened really fast....within two hours.....just chaotic'*, she then states *'I didn't like it at all. I thought it was too fast'*. Kim knows her GP who is male and believes she *'gets on with him ok'*. Kim went on to explain that she feels *'ok for seeing her doctor for illness [physical] and stuff'*, but when seeing them on this occasion for self-harm she felt *'uncomfortable'*. When asked what made her uncomfortable Kim said *'I was thinking what will he think, if I was going to be judged, which put me off going'*. Kim's mum and dad went with her to see the GP and this made her more nervous. The GP said he would refer her to CAMHS, but it might be a few weeks before she got an appointment. Kim said that following the visit to her GP she felt *'a sense of relief, but I was still very uncertain about it'*. When asked what the uncertainty was about she said both talking to her GP and the referral to CAMHS. Kim seeing her GP had happened approximately 3 weeks prior to my interviewing her and she had an appointment for CAMHS in 2 weeks time, but had been sent some information about the service.

In the interim it appeared that Kim's mum and dad remained anxious about their daughter's behaviour and her mum contacted the school for help. Kim said *'I think they went into panic mode and sort of just like, she needs help, we need to get as much help as possible'*. Kim told me it was the *'Head'* who put her forward for 1:1 counselling in school, *the Head signed me up.....well she asked me first if I was comfortable with going and I didn't see why not...so she signed me up'*. At the time of interview Kim had attended 2 sessions of 1:1 counselling and 2 sessions of group therapy. Kim's 1:1 counsellor is female and she finds the sessions *'good'*. Kim tells me that prior to going to the sessions she is *'anxious at first, but in the session I am a lot calmer'*. When asked what helped her to feel calm she said *'Probably that you don't feel judged by them and that it's confidential as well'*. Kim explains how these two aspects of counselling are very important for her. Kim also tells how *'the counselling in school is really helping so far'* while she waits to attend her CAMHS appointment.

In terms of attending the DBT skills group Kim talks about the benefits as being *'quite good because they teach you techniques on how to distract yourself or calm yourself down.....you can just handle self-harm like anxiety'*. *'They explain to you, you don't have to be alone in it.....So I think that's why the group helps because.....you're suffering in a*

way.....*not the only one doing it, so you don't feel so alone*'. Kim goes on to re-emphasise *'that you're not alone'*.

When we talk about the counsellors personal qualities Kim tell me *'the counsellors are very calm and I think that calms you. At the same time they are very understanding and they don't try to jump to conclusions. They are caring as well'*.

### **Past and future**

Kim later talks about when she has felt really down and the support she received from the teachers in school. Kim felt teachers also had a role to play. She said *'Certain teachers are more approachable...I think they should try and be approachable.....not judge you'*. Kim identified the Year Head and Deputy Year Head as being *'very supportive because you can go to them at any time and they'll just sit you down and let you talk to them'*. Being given time to talk appears important for Kim. She goes on to tell me about her *'really bad days and I just can't face anyone, they've just sat me in a room and said we'll just talk...and they will try and keep me as calm as possible and they'll be as calm as possible and they just let you talk about your problems which I think helps'*. Kim believes that on the occasions she has sat and talked what has been said is confidential, but acknowledges that if she talked about suicidal ideation the teachers would have to tell her parents, but this did not appear to worry or put her off talking to them.

Kim explains that *'lot of it is quite a taboo subject to be thinking about.....but if they [people] knew that it is well known, that it actually happens and not be a taboo subject I think that would help a lot of people to deal with it and say.....I'm not the only one'*. I followed this by asking Kim how we could get that message across to young people. She suggested *'use posters and put them up round schools.....if they see them around and there's enough of them I think people could look at them, but not draw attention to themselves'*. Kim goes on to suggest that there could also be presentations on self-harm in school, using assemblies and having cards with contact numbers on placed discretely in schools.

Kim and I also talked about advertising in GP surgeries. Kim suggested *'a lot of adults go to the GP, like older people.....they will sort of educate them as well, so that they know not to do certain things because it will make the person feel worse'*.

## Tina's Story

Tina is a 14 year old girl, who lives with her mother and father and younger sister. Tina told me that she has been using self-harm for approximately 12 months and that the behaviour was triggered by bullying at primary and secondary school. Tina had a friend present during the interview, they had been friends since year 7 at school.

### Self-harm and suicide

Tina's self-harming behaviour was triggered by bullying in primary school. *'I've had a lot of past stuff, bullying.....it was a lot in primary and I thought...if I was going to come up to school (secondary) it was going to be a fresh start, but I guess it weren't really'*. In primary school Tina told me that she once lashed out, not at the person who had been bullying her, but *'just lashed out and ran home'*. She goes on to tell me that she was *'angry and went home. It's hard for me.....it is really hard for me to stand up for myself.....I don't really think I have the confidence, so I always used to keep it in'*. Tina uses self-harming behaviour to *'get rid of stress and let out the pain'*. Tina is ambivalent about telling her mum partly because she is *'ashamed of it (her self-harming)'*, *'I felt really ashamed of telling my mum'*. Tina told me that she occasionally had suicidal thoughts, but these were only when she *'felt unable to handle anymore'*.

### Family and friends

Tina explained that a part of her did not want her mum to know about the self-harm, although her mother found out the day after the first time she self-harmed. *'Cos I was getting changed and she saw it and that's when I got more worried'*. Tina explained *'I didn't want me mum to know, because she was upset and mad, but when she found out she was actually supportive in a way, but she was mad as well'*. Tina goes on to say that she was *'worried about what she would be thinking'*, but her mother actually responded by telling her *'if there is anything worrying you just come and talk to me than hiding it inside yourself and keeping it in'*. I asked Tina if she had seen her GP about her self-harming, but she said she had not seen her doctor, but *'her mum was really supportive.....she sat me down and we talked about why and stuff like that and it really.....it was happy to get it off my chest and mums understand'*. Towards the end of the interview Tina tells me *'there's not many people out there have supportive parents.....so that's another thing why you need somebody out there for them'*. At this point dad came into the conversation. Tina said her dad was supportive, *'my dad knows about it.....but me mum and me have a bond and my dad stays out of it.....it's a girlie thing'*.

Tina does have a friend at school who she describes as *'supportive'*. When I ask her if she is able to confide in her friend she reverts back to talking about her mum. *'I'd rather turn to my mum.....she'll be supportive.....I don't like keeping things from my mum.....I feel bad keeping things from my mum.....so I'd rather go home and get everything off my chest and tell my mum'*.

### **Route into services**

Tina's mum had a connection with the ADHD Association and initially accessed help for Tina through them. Tina said she attended a local children's centre had 1:1 *'play counselling'* for approximately 6 weeks, but at the time of being interviewed that had come to an end. Tina found the counsellor *'really nice, she was very kind and really friendly so that made it ok'*. Tina also told me that during the counselling sessions she was *'shown strategies and new ways of dealing with it and how to move away when getting the thoughts'*. Tina further clarifies what strategies she learnt during the sessions, *'writing letters to people who have hurt you and then ripping them up.....just to get it out of your mind or writing down why you are getting them thoughts and then ask yourself a question, where is the evidence, who says I'm that'*. Tina also intimated that they did breathing exercises which she found *'calming and took your mind off everything'* and which she said she was able to use at home.

Tina is now participating in a DBT skills group that is run by Kooth within the school she attends. Her involvement with the group was arranged when her mum contacted the Head of Year as she *'was really concerned'* about Tina. The Head of year spoke to Tina about the group and asked her if she *'wanted to do it'*. When asked how she was finding the group Tina said *'I'm finding it alright because there's people around you all the same and you don't feel like you're the only one'*. Tina describes this as a good feeling *'because then you are not thinking you're the only one, you're just weird'*. When talking about the people who run the group Tina described them as *'friendly'*. She then goes on demonstrating insight *'they are a really quiet group....but I guess they are only getting use to each other'*. When I ask about the inconsistency of the group meeting (due to pragmatic problems) Tina defends the group saying *'it's just the way it fell and the people who run it are busy'*.

### **Past and future**

Tina talked about the need for more counselling services *'it would be good if there were more out there, if there was confidential ones for kids'*. *Like other kids can ring directly.....if they don't want their parents knowing, they can ring confidentially, kids don't have to worry about their mums knowing and they can get help'*. Tina reiterates how she *'felt alone'* and how important it is to know that there are others who self harm and having somebody who

they can trust to talk to is helpful. We moved on to talk of other services Tina might know about and she came up with 'Kidstuff' which she thought was an online service. I asked what she thought about using online services Tina's response being *'you don't really know who is over the internet.....it could be anybody trying to find out someone's secrets.....that's the worrying thing'*. Towards the end of the interview I asked Tina if there was anything she wanted to ask me, her response was *'will there be anything out there for people.....for people to literally know.....there's not many people out there that know there's services out there that they can ring'*. *'Maybe more advertising on it'*. *'Maybe go into different schools and advertise and speak to kids in schools.....somewhere for them to go and talk about their fears.*

## Julie's Story

*'Someone to come in who you can talk to, they only have to be there for comfort'*

Julie is a 14 year old girl, who lives with her mother, father brother and sister. Julie is the eldest. Julie told me that she has been using self-harm since the age of 10 years old and that the behaviour was triggered by bullying at primary school. Julie denies any suicidal ideation. Since her self-harming behaviour was exposed in December, 2012, Julie has had support from her GP, CAMHS, Camouflage and a DBT skills group.

### Self-harm

Julie's self-harm was the result of being bullied at primary school (year 5). Julie did not know how to handle it and kept it secret until she was 14 years old and her scars were seen by one of her teachers. She tells me towards the end of the interview that *'even though I was bullied in year 5 it is still going on now, people don't understand what effect it has on people'*. I clarified what she meant by *'still going on'* and she told me that it was not the bullying, *'that stopped in year 6'*, but she said she feels *'totally behind....and I still deal with it by cutting in case it happens again.....I get really scared and anxious.....it can happen again'*. Julie told me that her GP had said that *she could be traumatised, because it's always on my mind'*. Julie reiterated her shame about self-harming towards the end of the interview suggesting that for some people it is a *'big deal'*, *'people say we do it for attention or if we want to kill ourselves or whatever, and we don't.....that makes people puts people off telling other people and getting help, in case they think that'*.

### Route into services

Julie's self harming behaviour was discovered by her teachers at secondary school. Julie's Head of Year teacher phoned her mum, Julie describing this as *'horrible'* as she *'felt ashamed'*. Once mum was informed about the self-harm Julie was taken to her GP and referred to CAMHS. Julie said that she felt *'awkward'* seeing her GP as she stated *'we see different ones every time we go'*. While Julie felt *'OK'* when seeing the doctor, she believed that he had not listened to her *'really fully'*. The GP referred her to CAMHS and this made her feel *'a bit better'* although she did not know what CAMHS was. The GP did try to explain what CAMHS was and Julie said she was relieved to know *'they were a group of people who do it more than doctors'*. Following her GP appointment Julie waited 3 to 4 weeks for her appointment with CAMHS. For her first *'assessment'* appointment Julie and her mum attended, after that she had a further 2 appointments that she attended on her own. Julie

said *'I liked it better when it was just me'*. Julie describes the female counsellor at CAMHS as *'fair, one of those people you can feel comfortable talking to.....she seemed a bit supportive'*. Julie and her counsellor made an *'appointment plan'* and within this was her referral to Camouflage. When interviewed Julie appeared to have appointments at CAMHS approximately once every 3/4 weeks and I asked her how she felt about going back after the Easter break. Julie was hesitant in her answer and when asked what that was about she said *'I don't like talking about it, but I like talking to her because I know no-one else will find out, that's one of the things they tell you'*. Julie trusts her counsellor at CAMHS and likes it being *just her'*.

From CAMHS Julie went on her own to Camouflage. Julie said *'they helped me with things, with my scars, they were good'*. Camouflage matched her skin tone and then prescribed the appropriate make-up for her to use at home on her scars. Julie said *it makes you feel more confident'*.

With regard to the DBT skills group she attends in school, this was suggested by her Head of Year *'cos she knows.....and she came to ask me'*. Julie describes the group *'I like it, but it's a bit awkward'*. The awkwardness is due to the fact that they have only met on 2 occasions and they *don't really know each other'*. Julie clarifies this for me by telling me *'there are 4 of us in year 9, 3 of year 8 and 2 year 10s'*. Julie sees the mix of ages as being *'a bit better cos people from my year I talk to. Otherwise it would be people I didn't talk to and then I wouldn't trust them as much'*. Julie is able to articulate the benefit of the group for her. *'That I'm here in a group with people who I've sort of seen and they've been going through what you have been through. You feel comfortable talking about it because people won't judge you'*. Of the people who run the group Julie describes them as *'nice, really, people that you know you can talk to'*. She tells me that in the group they learn *'breathing methods'* and *'how to get a clear mind'* and explore *'why we do it'*. Julie seems to trust the group as *'they've all self-harmed'*.

## **Friends**

Julie implied that she had talked to friends, but added *'I don't tell them all of it'*. She goes on to clarify that *'I'd tell them I was upset, but I wouldn't tell them why'*.

## **Past and future**

When asked to think back to a time that was difficult and what she would have liked to happen Julie said *'talk to me mum'*. When I asked what stopped her telling her mum she said *'it was hard, I thought oh, she'd shout at me.....shout at me for doing it'*. I then

asked Julie if there were other services she might have used. Julie said *'not at the time because I didn't know them'*. She went to say that if she had of known services she could have contacted she would have. I more specifically asked about Childline, but Julie told me that she thought that *'it was for kids who had been abused'*. We then talked about the role of school in self-harm. Julie said *'schools need to do something, because they did bullying, but they don't do what it can do to people.....doing it this way (advertising self-harm in schools) may help people to understand it more'*. Towards the end of the interview Julie talked about someone going into schools *'someone to come in who you can talk to, they only have to be there for comfort, its alright, so you can talk to them'*. Julie also mentioned the need for schools to be more knowledgeable *'so if people did find out about it, it wouldn't be such a big deal'*.

## Nina's Story

*'As soon as you do it you just feel better, the tensions gone, the emotional pain is on the outside, it clears your mind'.*

Nina is 17 years old and currently attending college and lives with her mum and dad. Nina has been using self-harm since she was 12 years old. Nina tells me that her self-harming behaviour was triggered by a friend, who used the behaviour to make her feel better. Her self-harm has involved cutting, burning and food misuse, she has also had suicide ideation. Nina also told me that none of her family knows about her self-harm and she has never used services.

### Self-harm and suicide

Nina tells me that her using self-harm was triggered by *'my best friend at the time.....she kind of triggered me into it. She told me everything.....how it made her feel good.....and I wanted to feel good...so I done the same'*. Nina had been bullied *'all my life'*. Nina was bullied in primary school, where she said she had *'no friends'*, and in secondary school she had 3 friends, but the bullying continued. Nina put this down to *'so people must always just find fault with me'*. Nina likes to present herself different to mainstream teenagers so sees herself as being *an easy target'*. Nina explained how when she initially start using self-harm it was good, *'as soon as you do it you just feel better, the tensions gone, the emotional pain is on the outside, it clears your mind'*. Nina is also able to articulate the downside of self-harm, particularly when *'it carries on'*. *'When it carries on it goes worse, scratches like that, to that big (she indicates the length of scratches).....after the buzz has worn off with feeling better I felt terrible, guilty, bad'*. She goes on to explain the meaning of her scars, *'because you've got the scars then you'll remember that time.....these people (the bullies) have a place on my body and that's how I see it now'*. Nina blamed herself for the bullying. *'It was me being imperfect.....you wouldn't be bullied if you had blonde hair, you wouldn't be bullied if you were skinny...'* Nina explained that being *'deserving'* of it and in some way it made her *'feel better'*. Nina told me that the good feelings from using self-harm last for approximately *'one year or so'*. From the interview it appears that it was the permanency of the scars that challenged Nina's use of self harm.

Nina describes self-harming as *'addictive'*. *'My whole life revolved around it, you couldn't look at anything without judging what it would be good for.....is that hot enough to burn you.....is that sharp enough to cut your skin.....if I smash a plant pot I could cut.....I could*

*strangle myself with the jacket*'. Nina said that she has worked hard *'to get away from it'* and now she is able to see every day objects as *'just normal objects'*. Nina also told me how it progressively gets *'worse'*, she describes how initially she used a *'coke can that would probably just make a scratch to a compass to make a deeper scratch to a .....and it just got worse and worse'*. But for Nina it felt good because *'you've got control...it's private to you and you know it's there so you're happy that no-one knows like a secret you can keep it for yourself'*.

Nina has had suicidal ideation. She tells me *'that was one of my main thoughts.....it was just so easy to end it all than just carry on.....when you're really bullied that badly you just think any way out of it.....better off gone'*.

Nina has taught herself other techniques to deal with emotional pain. She uses behavioural techniques using chocolate as a reward for not cutting. She also uses drawing and listening to the lyrics of music as coping strategies. Music was particularly pertinent for stopping harming herself and her suicide ideation. Nina told me that a lot of the lyrics she listens to talk about self harm and *'things getting better'*. Nina also believes that *'a lot of musicians have dealt with it'* and tells me *'if they've dealt with it and got something out of life I can'*. One musician in particular made her aware, through publically acknowledging his experiences, that *'you can still be loved if you are different'*.

At the time of interview Nina tells me she has not used self-harm for nearly a year, but admits to a *'slip up'* in September, 2012.

### **Family and friends**

Nina's parents have never known about her self-harm, she tells me *'I chose to keep it all in and be self-destructive towards myself.....at the time I thought I deserve it'*. While Nina insists that the self-harm was a result of being bullied, she does also mention *'a lot of home problems going on'*, and this might offer insight into why she kept it to herself. Much further into the interview she tells me about her nan, who she visited most days and who she describes as *'her world'*, dying and how that *'triggered her'* and *'she was so young (13) she didn't understand'*.

Her friend that Nina said instigated her self-harm also played a part in her stopping the behaviour. Nina said that she looked at *'how dysfunctional her family was.....how everything revolved round the cutting.....she went for a shower to shave her legs and they'd be watching, supervising.....I didn't want none of that'*. Nina also indicates that although she spoke to her friends, she does not trust them enough to tell them about her

self-harming. Nina tells me that if she did tell friends their response would be *'freak, the bullying or I've got to tell someone, you're in danger'*. Paradoxically Nina bases her prediction of such reaction on how she would react.

### **Route into services**

At the beginning of Nina's story I do state that she has not used services. Her reasons for not accessing services included *'I didn't want to hurt anyone'*. Nina believed that if she had told her GP and it happened when she was under 16 *'the doctors have no confidentiality, they can phone my mum and dad straight away'*. Nina goes on to tell me that *'if it got really bad I would have told someone or rung an ambulance.....I didn't feel the need when there is other people out there worse than me'*. However, Nina has had support over the period of time she has used self-harm. Initially her friend, who she said had triggered her self-harm, gave her a KOOOTH card and while at first she was reluctant to contact them when she read it she thought *'wow...I'll go on it now'*. Nina accessed an online local support group, Kooth, who she said *'helped quite a bit'*. Nina spoke to them *'quite a lot'*, she liked the fact that you did not have to give your real name, it was confidential, and while waiting to speak to someone there were surveys you could fill in, Nina using the latter as a way of challenging herself to stop the self-harm. Nina preferred to access the service online rather than ringing someone, for her this felt *'very safe, no-one can find out and no-one can judge you'*. For Nina it was the fact that *'these people are doing this everyday'* that enable them not to be judgemental. Another positive aspect of the service for Nina was the instant access *'you only had to wait 10 minutes for there to be a real person, so if you know you've got that help instantly and you're not waiting weeks for help that's fine'*. Initially Nina used the service regularly, but it got less over time and now she does not use them at all.

When asked about other internet and phone line support services Nina said she had never used any of these. She saw Childline as a service for *'kids getting beaten up.....I'd rather have a child safe than me at the time.....Childline is really for children and I wasn't a child'*.

Nina had contact with the student welfare service within the college, when she was having some difficulties at home. Nina said she had seen the counsellor *'for a few sessions'* and eventually told her that she had *'dealt with things in the past such as self-harm, burns.....and that's how we got talking about it'*. When asked about what prompted her to tell the counsellor about her self-harm Nina said *'it felt really good (when she told her) because I'm probably not going to see her that much, she's not my best friend, so I can just talk to her, she can't judge. I prefer to talk to strangers about it'*.

## Past and future

When asked about what could be done to alleviate the problem of self-harm Nina indicated that people need to have more knowledge about it. For example she explained that *'you always think of wrists'* going on to suggest that parents should be mindful that there are other place on the body that can be used for self-harm. She relays a number of ways to avoid being found out. Nina suggests that *'there should be more posters around.....alcoholics get a lot of help.....but there's nothing like help towards self-harm'* that would help inform people about self-harm. She also feels strongly about self-harm being advertised on the television and billboards. Nina was also careful to explain that young people need to be warned of the dangers of self-harm, particularly in relation to it's addictiveness and it's progressive nature.

In terms of school, Nina is sceptical mainly because of her concern that if *'school find out they are likely to tell parents'*. Nina's experience of this, with her friend, is that it only makes things worse, particularly if the family is not stable. That said she does believe that teachers need more information on self-harm. Her own experience in school was a very negative experience. Near the end of school she told me that she *'did speak to someone (a nurse resident in school) but I never told her I self-harmed because I knew being under 16 it was like phone home. So I told her I was depressed and I'd had these suicidal thoughts, but she never said anything.....it was more brushed off because lots of teenagers have home problems and school problems, so it was like.....normal teenager, bye'*.

We return to the Kooth cards and talk about them being left in places where young people could have easy, but discrete access to them. Again this for Nina brings up inequalities in promoting health behaviour, likening it to smoking and how 10 people would help her if she wanted to give up smoking, but if she tells of her self-harm she would simply be branded a *'freak'*. She believes self-harm to be *'in the same line as drinking and smoking because it is addictive and it's harming'*.

## **Lizzie's Story**

*'I felt like it was making a big deal, I didn't really think it was such a big thing...but now....I'm glad I've had all those people....I'm glad they got involved otherwise I would never have been stopping...coz I needed them to stop'*

Lizzie is just 14 years old, she has a mum, dad and older sister, but only lives with her mum and older sister. Lizzie started self-harming around January, 2013. Lizzie has contact with her GP, CAMHS, a Kooth counsellor who comes into school, a DBT skills group run by Kooth within school and Camouflage with regard to her self-harm.

### **Self-harm and suicide**

Lizzie's self-harm was triggered by *'stress at school, stress from people, friends being horrible and then the family arguing'*. Lizzie describes these *'all happening at once'*. She told me that she heard one of her friends saying that *'she'd done it and it helped so I thought I'll do it'*. Lizzie told me that her friend said *'it just relieved the stress'*. Lizzie acknowledged that it relieved her stress but followed that up by saying *'it's not really a good thing'*. Lizzie clarifies this for me *'I mean the reason I done it was 'cos someone else was talking about it and saying how good it was.....people shouldn't be saying its good because it's not'*. Lizzie told me that the reason she carried on self-harming was because of the relief she got. She told me that, *'she told herself I'll do it once and then I'll never do it again...but it's not that easy'*. When asked if she had ever felt suicidal Lizzie said no.

### **Route into services**

Towards the end of February Lizzie decided to tell one of her teachers that she had been using self-harming behaviour. Her telling was influenced by a friend, *'she sort of went, you've got to tell someone otherwise you're not going to get help, you're not going to get better'*. The teacher she told was her Progress Leader, who she said *'kind of talks'*. I asked if she went to see her Progress Leader (female) there and then and she said she had. I asked her what would have happened if she had to wait for an appointment and after some thought Lizzie said *'I don't think that would be good, because if you've got a problem you want to deal with it now, you don't really want to wait'*. I asked Lizzie how she felt about telling her to which she replied *'ok, because there's quite a few people in our year who do it, so I think she is use to it'*.

After telling her teacher Lizzie was asked if she wanted her teacher to phone her mum. Lizzie was told *'we don't have to ring your mum because it is confidential.....but I thought I'd rather them ring my mum than me try and tell her....school telling her may be easier, and it was'*. Lizzie's mum was contacted and told over the phone about her self-harm and about a possible referral to CAMHS. The school said that they could refer her to CAMHS, but she would get an appointment quicker if she was referred by her GP. Lizzie's mum made an appointment for them (mum, dad and Lizzie) to go to the GP. Although the GP asked Lizzie what the problem was, she goes on to tell me *'he's a doctor, he doesn't sort of really...he sees sick people, he doesn't see people who have problems like that'*. The GP did refer her to CAMHS. When interviewed Lizzie had been to CAMHS twice and had been referred to Camouflage. Lizzie describes her first appointment at CAMHS as *'good...she really understands me'*. Lizzie initially saw the counsellor at CAMHS on her own and her mum joined them later in the session. At the end of the assessment Lizzie was told that she *'didn't need counselling because she was already getting counselling from Kooth.....but they had to make me another appointment because I needed Camouflage'*. Lizzie also told me that an alternative would be for her to go to Changing Faces, a charity, but *'there's a big long waiting list.....its like 11 months or something'*. At this point in time Lizzie had been tested at Camouflage and was waiting for the make-up to come.

Lizzie also told me about a man who came to see her from young carers. She said she thought the counsellor at CAMHS had referred her, but was uncertain of why he had visited. I asked her if she did any caring, but she said not and did seem bemused by it. She said that he saw her after her grandma died, but again denied that she was a carer.

I asked Lizzie how she felt about being referred to CAMHS. She told me *'I was quite nervous, it's obviously scary when someone.....your talking to a new person and I'd barely got use to the counsellor'*. Lizzie also told me that she *'felt like it was making a big deal, I didn't really think it was such a big thing...but now....I'm glad I've had all those people....I'm glad they got involved otherwise I would never have been stopping...coz I needed them to stop'*.

In the meantime Lizzie's Progress Leader referred her for counselling via Kooth who she sees for 1 hour per week. Lizzie told me that there is a waiting list in school for Kooth counselling, but she thinks *'someone dropped out so I got in'*. The Kooth counsellor asked Lizzie if she would also be interested in attending a DBT skills group that they run at her school. Lizzie describes the counsellor as *'deadly'*, which she assures me is good. Lizzie tells me *'I like her in the counselling....she just helps me'*. Lizzie told me that when she was asked to join the group she felt *'it was a bit worrying, other people being there, can I say*

*something....share it...will it be confidential....if they're going through the same thing, they won't make your problems worse'. Lizzie has joined the group and attends once per week and tells me 'it makes you feel better...a lot better.....it's not really the fact that other people are doing it...you want to know other people are trying to get help too....it's more for people who want to get better...it gives you a boost'. I asked Lizzie if she had thought about going online to contact Kooth, but although she knew about it she had not used the online service saying 'I'd rather talk to someone'.*

### **Family and friends**

I asked Lizzie what worried her about telling her mum and dad about her self-harming. She said *'well the fact that they might not like, accept it...me dad doesn't accept it....he just thinks I'm faking it, thinks I'm attention seeking, but then me mums more good with it...she was like lets talk'. Lizzie told me that she 'didn't want to talk to her mum about it because I was scared she would get upset. She didn't want to talk to any mates about it in case they thought it was funny....I didn't really want to talk to anyone about it'. Lizzie also said that her older sister 'was good with it, she understands'.*

Towards the end of the interview Lizzie tells me how she persuaded her friend to go to CAMHS, *'I was like you go, there's nothing to be scared of, you go and get help...they're dead nice to you'. Lizzie think that a lot of persuasion comes from peers 'not everyone knows there's help around...so you tell them that it helped me.....and it's really bad and you can get help'.*

### **Past and future**

Lizzie reflects on her own experience of getting counselling in school. She tells me that she thinks *'there's only 2 (counsellors) and there's quite a lot of people who do need counselling, so we need to get more helpers...coming in or working with the school....even just coming for an hour to see one person would just make the difference'. She also talked about educating in school assemblies 'people don't talk about it and they need to'. She goes on to explain that teachers and pupils alike do not know very much about self-harm, that although they have counselling in school it 'feels very put away'. She vociferously re-iterates that 'those people (those using self-harming behaviour) think it's a good thing and it's really not.....have an assembly about self-harming.....just do it!' Lizzie also talks about the need for posters in school, *'it's like there's a smoking regime at our school and that's advertised, there's posters all round, but there's nothing for counselling, nothing around school. In my school there's more people who self-harm than smoke or drink'.**

Lizzie told me that she had been given a *'big sheet with numbers on'* from CAMHS, but she said *'they said the numbers and e-mails, it didn't say what they do.....I don't know if I should ring them, if it's the wrong thing'*.

I ask Lizzie if she could have accessed counselling in school before she started self-harming would she have done so. *'I don't know, if you go into our school and say I've got depression, they don't really give you counselling, it's more if you've got a physical problem..... Yeah I don't think I would end up doing it in the first place if we had that'*.

## **Linda – Fiona’s mum**

*“I’ve just got so many things going on in my life, she said, and you don’t need to know. I said, well, truly, I said, I do, because I’m your mum.”*

### **Role of mother**

In her role as a mother Linda goes through 4 intrapersonal phases in relation to Fiona’s self-harm; disbelief, fear, hurt and self-blame. Linda’s disbelief comes at the start of the interview, when in her opening statement she tells me *‘I just couldn’t come to terms with the fact of why she’d done it and she said to me, I’ve just got so many things going on in my life, ..... and you don’t need to know’*. Linda response was *‘I should be able to help you and if I can’t help you, I said, I should be able to find somebody that can’*. Linda reiterates her position as a mother at the end of the interview *‘I’ve always said to both of them (Fiona and her brother) if you’ve got a problem, come and tell us, if we can’t deal with it we will go and try and find somebody that can’*. Linda’s fear is also explicated at the start, *‘it frightened me a bit because ..... am I doing the right thing’* ‘I know sometimes she’s upset and I think to myself, I don’t interfere... she says, I’m getting in the bath and she’s got a mania for shaving her legs.....And that’s what frightens me because that’s where it all started off’. Linda tells me that Fiona told her she used razor blades to self-harm. While Linda does not say she is hurt by Fiona’s self-harming, she does make statements that indicate she might be. For example she tells me, *‘its obvious...you need some sort of help.....you can’t talk to me about your problems for some reason I don’t know...you obviously need to talk to outside people’*. Finally comes self-blame and well into the interview Linda asked me *‘where did I go wrong’*.

### **Interpretation**

Linda has interpreted Fiona’s behaviour as a way of mediating *‘the horror’* of it, *‘then I realised at least she’s come and told me what she was doing and then it was an obvious cry for help’*. Linda then goes on to look for causes that could have led to the self-harm, *‘she had a lot going on over the last two years with dad not being well and all that. I think she found it difficult to talk about it’*. Linda also tried to explain her own position as a mother in relation to Fiona’s behaviour, *‘with everything that’s been going on with her dad and one thing and another, you tend to put things on the back burner....but I was trying to keep on top of her and keep on top of her dad’*.

## Seeking help

Linda does not know where to start in terms of getting help. She tells me that on hearing of Fiona's self-harm she thought, *'where do I go from here, because I wouldn't have known what to do or where to go'*. Linda initially went to her GP on her own. *'I went to the doctor's and I spoke to the doctor and said to the doctor that I'd found out she was self-harming and the doctor said we need to get in contact with CAMHS. The GP also told her 'to try and find out why she is doing it'. Linda told me that the GP was 'there and give him his due he was really good with us'. She then explain that on her return home from seeing the GP, she tells Fiona that she has made an appointment for both of them to go to the GP, saying that, 'I can't let this go....if I do then other people notice it (scars) they are going to say well what's your mum done about it'. Linda describes how 'It took a while for us to get into CAMHS, we did, we eventually get into CAMHS' Linda clarifies this as it taking approximately 2 or 3 months. While waiting for the appointment Linda turned to the Minister from church to try to 'push it (the appointment). and we spoke to different people in CAMHS and then we got therapy through CAMHS.....I think we were with a counsellor maybe 2 or 3 months'. It is interesting that here Linda uses 'we', almost as both needed and were receiving help.*

When I clarified what help Linda had got from CAMHS she initially said that she *'did not get anything'*. She later said *'they gave me advice what to do at home, in other words make sure there are no belts, no razors.....try and put them all away'*. Linda considers this as not helpful advice, telling me that *'she did put everything out of harm's way.....but she's old enough and big enough to know'*, and describing it as akin to smoking that *'if teenagers wants to do it they will find a way regardless of what parents do'*. Linda goes on to talk about the need for trust and as a mother trying to find the balance between trusting Fiona and keeping her safe. Linda describes the help she had from CAMHS as *'not a great deal.....I wouldn't have even said it was help, just advice that they've given'*. Linda does concede that *maybe she could have gone to them.....but I didn't.....it was my choice because I just had too much on my plate, worrying about this and worrying about that'.*

Linda told me Fiona started to use self-harming behaviour approximately 12 months prior to her referral to YOS, this differs from Fiona's account. Since her involvement with YOS Fiona and Linda have had further support with Fiona's self-harm. Linda told me she had spoken to Fiona's caseworker who had asked Linda if *'she was ok?'* She also told me that Fiona's YOS leader had helped her with *'parenting issues'*, she told me that she had attended a *'parenting course'* and that Fiona's YOS leader has *'always been on the end of a phone'*. Linda reiterates this is also the same for Fiona's caseworker. She goes on to tell me that *'when I've been a bit concerned about anything they've dealt with it....they've got back to me'*. Linda

also suggests that both these people have a relaxed manner which she finds reassuring. She tells me how, if she contacts them regarding Fiona missing an appointment with them (said she had only missed 1 or 2) and explains what has been going on at home *'they just said, it's okay, it's fine'*. Linda perhaps is reassured by this as she does her best to ensure Fiona attends all her appointments, *'I've always kept on to her....because I didn't want her going off the rails again and go down the wrong path'*.

### **Other help**

We talked about her relationship with the church and the role the minister played in helping her. She told me that the minister is *'always on hand'*, suggesting that the minister having time for her was important facet of the helping process. The minister did visit Fiona at home at Linda's request and spoke to her about her self-harming behaviour and what had led to it. Linda told me that he *'did not actually go into detail (about what he and Fiona talked about) because obviously she is not going to speak to him if she thinks he's going to come back and tell me. But then (after he had spoken to Fiona) I felt better'*. While this could be seen as indirect help nonetheless Linda felt comforted by it.

In addition to the minister Linda did seek help from friends. Most of the friends she spoke about attend church, but she makes a distinction about which friends she is able to talk to about Fiona's self-harm, *'there's only certain people that you can relax and talk to about it'*. Linda describes one set of friends as *'lovely people'* but due to their being older (over 65) and *'having had lots going on in her life over the past 12 months'* she feels unable to talk to them about Fiona's problems. However, another couple she is good friends with, who she tells me are *'in their 30s'* and that she is *'a teacher and she works at a teenage school'* she is able to speak and confide in her about Fiona's self-harm. Linda tells me that this particular friend has *'always helped.....because I know I can speak to her and she can sort of explain it a bit better to me'*. Linda goes to tell me that they (friend and her husband) are the sort of people who *'just ring up and say, are you okay, do you need anything.....and it's just nice to know that they're there'*.

Towards the end of the interview, when I ask Linda if there is any other sort of help she would have liked, she re-iterates *'where do you go for help?'* Linda then tells me about her visual problems and her links with RNIB and how she attends different events. Linda told me about an old friend from school she met at an event who she told about her problems. He told Linda *'if there's anything we (the organisation) can do as regards to counselling....we're there on hand as well.....you can always just ring us and say look I need a counsellor or I need to somebody to talk to'*. Linda then tells me about another *'outside agency'* she *'has*

*been able to go to' and then said 'it's knowing who to contact.....it's just from talking to different people that you think, oh well I'll give them a go'.*

*We go back to the question of what more help she would have liked? After some thought, Linda tells me 'I don't know.....you think, who do I say it to? It's not until after the event that you realise that there's more help out there.....it's just accessing the help and where to find it.....people don't tell you that there's other outside agencies.....you have to go and find them for yourself.....you've got to go and do everything for yourself because nobody tells you anything'.*

## Valerie – Lizzie's mum

*"t really worries me, I don't know why it just does. I'm scared in case it goes on to something else, and that's me worry"*

### Role of mother

Valerie was aware that Lizzie had cut herself on one occasion *'I know she's cut herself once because she told me...I was just sort of.....alright, okay don't do it again'*. When, one month later Valerie discovered the seriousness of Lizzie's self-harming she thought *'I can't believe this, I just don't know what I was dealing with.....I find it terrible'*. Valerie repeats later that *'she is only 14....just so scary'*. Valerie repeats statements such as *'it's scary, quite scary, so well out of my league.....with this cutting.....it's a frightening thing when you don't know...how do I deal with this?'* When Valerie joins Lizzie towards the end of her first session at CAMHS the counsellor tries to reassure her that *'it's nothing you don't know'*, but then Valerie tells me *'so it was a real shock'* when she is told *'it gets on her nerves I spend too much time on her'*. Valerie tells me that she could not deny this and then in the session she then asks *'is it my fault'*. Valerie told me that she returned home *'doubting myself'....I'm a bit nervy if it's something I've done'*. Valerie explains that the counsellor said *'it's not your parenting skills because we're quite open'*. Valerie becomes upset at this point and tells me *'I think this is the first time that I've spoke to you that I haven't....coz all I do is cry, every time I mention it.....and.....because it really worries me'*. Valerie goes on to explain that *'Because once they start cutting they can do anything else can't they?'* When I ask Valerie to articulate her worry she responds by saying *'I don't..... know, because she could kill herself, she could do anything...it's worrying, isn't it?'* Valerie tells me because of her lack of knowledge re self-harm she has read up on it and that is how she knows *'it leads to other things...that people do terrible stuff.....and it frightens me...I think is it the start or is just going to fade away? I don't know. She's a kid. You don't know what they are going to do'*. Valerie later tells me how initially she was *'pussy-footing around at first'* and then reflects *'maybe you do need to sort of go somewhere.....because you don't know what you're dealing with'*. Valerie explains that *'it's scary when it's yours, it's different if it's somebody else'*. Towards the end of the interview Valerie recalls going into town with Lizzie and acknowledges to me that *'we don't give compliments very good'* but on this occasion Lizzy said to her *'you're an all right mum, you've just got to believe it'*, Valerie said *'so I thought well I'll take that, that's quite good'*.

## Interpretations

Valerie tells me that she *'thinks there's a few problems just all come at once.....her gran died last year and a few months later her other nan had died.....and her sister has learning difficulties...that hard for her (Lizzie) as she's getting older.....so everything's just been building up'*. Valerie goes on to say that Lizzie is *'quite open....she doesn't keep nothing to herself....I don't know...I just don't know about it...that's the thing....I don't know nothing about it (self-harm)'*. Valerie believes that *'there has to be a pinpoint, it's just getting to it'*. Again she reiterates that she thinks *'it's just a few things that's got to her...at the same time and she can't cope, because she is only 14'*. When she is explaining this to me it feels as though this is Valerie's way of sharing the responsibility. Valerie also tells me she thinks *'it's also a thing teenagers learn...but this was very hard'*. Valerie's account of her own *'shock'* was based on the fact that she believes Lizzie to be *'quite level headed'* and again reiterates that this is *'well out of my league'*. In terms of self-blame, Valerie talked about Lizzie having to *'get her boundaries back.....I was giving her a bit of leeway and I thought I'm not doing myself any good here, nor her'*. Towards the end of the interview Valerie tells me she *'hates talking about it'* and repeats this 3 times as though frustrated by it being *'not a thing I deal with....I don't know.....as long as she is alright'*. Towards the end of the interview Valerie concedes that *'my nerves are terrible....I don't know what the problems is to be honest....but there's a problem because she's cutting herself'*. Valerie also tells me about how Lizzie covered up her scars, for example making sure she was never undressed in front of her mum, telling me *I didn't take much notice because it was colder....maybe in summer if she was doing anything I'd have noticed'*. She then recalls a time when she gave her Tubigrip to hide the scars and reflects *'why did I do that? You shouldn't do things like that. When I look back, I think my god, why did I give her that to hide it?'*

## Seeking help

Valerie received a phone call from school asking her if she *'had seen her (Lizzie's) cuts?'* Valerie said this was approximately 1 month after Lizzie had originally told her that she had used self-harming behaviour. Valerie told the school that she did not know and she explained to me that Lizzie had *'done them the night before and they were all on her arms and her leg.....I thought she'd just gone like that (mimics cutting action) .....but this was really bad and that was the first I heard'*. The school told Valerie that Lizzie had talked to a counsellor, but also advised her *'to get on to someone about it.....to get in touch with CAMHS, but I have to do it through my doctor'*. Valerie describes being told by the school as *'a right smack in the face'*, explaining that *'we're usually quite open.....we talk about all*

*kinds'. Regardless of Valerie feeling this way, she does tell me 'I think the school's quite a good school....if anything's wrong they get in touch with you'.*

Valerie told me that she *'didn't know what she was going to do'*, but she did get in touch with CAMHS first and then rang to make an appointment with the GP the following day. She said that when Lizzie returned home from school she felt that was *'treading on eggshells'*. Valerie already had an appointment for herself the following day, but the surgery brought it forward which she appeared relieved about. Valerie told me that she and Lizzie's dad took her to see the GP. She told me that the GP *'didn't ask to see her scars or nothing, he just was asking a few questions and then her referred her and it was quite quick'*. I asked Valerie how she felt about going and telling the doctor, her response was *'I was more concerned about her (Lizzie) it didn't matter about dealing with the doctor or anyone, it was more to get her help, I didn't care who I went to'*.

Valerie said that she has only spoken to CAMHS on one occasion. Her rationale for this is Lizzie *'doesn't was to sit and talk in front of me, she doesn't does she? When someone's with you, you don't say the same things do you?'* Lizzie did see the counsellor at CAMHS on her own and Valerie was asked to join them towards the end of the session. Valerie describes the CAMHS lady as *'nice, she put her (Lizzie) at ease and that's the main thing'*. Lizzie only attended CAMHS on a couple of occasions, but does see a counsellor in school. Valerie seems to know very little about the school counsellor, but did say *'they said they're going to carry on and carry on with that....when she needs it'* and that *Lizzie comes home and goes I've seen her.....so I know when she's been to see her (Counsellor) apart from that I don't know...and it's very scary'*.

After attending CAMHS, Lizzie was referred to Camouflage. Valerie describes staff at Camouflage as being *'lovely.....a really nice girl.....they were youngish girls so that was good'*. I tell her that I have only had telephone contact with them and this prompts her to tell me *'they're really, really really good.....they were also talking to her constantly about it (her dancing) and she was dead at ease....I just sat back and watched, it was lovely'*.

### **Other help**

While both Valerie and Lizzie have regular contact with her dad he appears to have offered little support in relation to her self-harming. Initially he did go to the GP with him, but like Lizzie, Valerie reiterates, *'her dad's just doesn't.....he's not having it...he doesn't want to know.....he didn't believe it.....we've had that battle'*. Valerie told me that Lizzie had tried to explain to her dad that she had gone to CAMHS to *'get a counsellor'* but he said *'oh you*

*don't need it because you haven't done nothing'. Valerie explained that she also told him because 'I was scared in case anything else happened, if she did something really bad....I thought it'll be on my conscience forever and I was sorry I told him, I shouldn't have done that'. Valerie told me that Lizzie did not speak to him for a few weeks and is now seeing her dad in 'a different light' and that she has had to say to Lizzie that she can't be 'like this, just talk to him'. Lizzie's response to this plea from her mum was 'I'm only doing it to make you feel better' and Valerie reflects 'at her age, making me feel better!' Even though Valerie acknowledges that her dad does not believe Lizzie's self-harming to be a problem, or that she has actually done it, she also said 'I feel really mean, because I usually involve him'.*

*Valerie talked about seeking help from a friend. 'I talked to me friend about it, but that's it. She (Lizzie) wasn't happy that I told me friend, but I said I had to tell me friend, I need someone to talk to'. She also repeated that 'I told her dad and that backfired on me'.*

*When I ask Valerie what other help she might have found useful she tells me 'I don't know, because it's nothing that I've experienced before'. Valerie reiterates the importance of getting help by telling me about her ringing her GP, 'I said look this is important.....she's self-harming and I need help now....so I'm not beating around the bush, I'm not waiting a week or so'.*

*Within the interview Valerie asks me a number of rhetorical questions, 'Why do they do it? Why cut themselves? Of all thing cutting themselves. It's like scarring yourself. I mean it's really scarred, she's a young girl. Is there other ways she can do it then? After the last statement Valerie tells me 'I feel horrible saying that.....because she does go dancing and she goes doing other stuff'. Again Valerie gets upset and tells me 'I'm sort of looking at her, hiding herself with long sleeved tops...oh gosh, if she hadn't have done that she wouldn't be doing this....she hides herself and it's a shame, isn't it?' Valerie then goes on to say 'they should teach these kids when they get to 10 and 11 what the consequences are going to be if you do something like that'. Valerie then tells me that she knows there is 'a counsellor in school and you can go to them, because I know they've got a smoking woman.....maybe if they did something about self-harm'. Valerie said 'no-one sort of gives you a book to say this is what happens.....like this self-harming, you don't know if you're doing good or bad'. Valerie does suggest having help for mums 'is a good idea, because you don't know anything'. She goes on to say it might be good to have 'someone to talk to'. We go on to talk about having information leaflets and she asks if this would be the 'schools or doctors who would organise that'. Valerie then goes on to tell me that 'a woman at school who went into the youth club to talk about self-harm and I thought that's good'.*

Valerie does think, as a mother, it would be helpful to have someone to talk to because *'it's my daughter and it really, really frightened me'*. She also tells me *'she's alright but it saddens me.....hopefully she will be sorted and hopefully you can get information in schools'*.

### Jean – a foster parent

Jean is a foster mother who has looked after 2 boys, Alex and Stephen, one who was suicidal and the other who used self-harming behaviour. The information in the transcript is limited in terms of this project, but does give some insight into how she dealt with the boys behaviour and what support she had and what support she would have found helpful.

Jean tells me that *'all kids are different, but you can tell when there is something up'*. She tells me that Stephen would *only give you a little tiny bit of information and I would try and encourage him to talk'*. Jean denied that she knew about Stephen's suicidal behaviour or about Alex's self-harming prior to them coming to live with her. She told me that she believed people who are suicidal do not like to care and recounted how she had said to Stephen *'isn't it a tragedy that you don't care about nothing, only yourself'* and he responded by saying *'I hate you because you've made me care'*, Jean pointing out to me that people who are suicidal *'don't like that'*. Jean tells me that *'you take it in your stride for keeping an extra eye on something'*. She describes some of the ways she does this, *'shouting up from the bottom of the stairs because you can't invade their space'*. Jean describes Alex as *'a lot bigger than me'* but then told me how *'he'd sob like a little boy'* when he saw his scars from his self-harm behaviour. Jean told me that Alex was 12 years old when he came out as being *'gay'* on a social network site, the consequence being that *'he wouldn't go to school'*. Jean said *'no-one had researched anything that he was gay'* and it was her intuition *'a gut feeling'* that she confronted him with that being the reason he did not go to school. Jean talked to him about it and was *made up'* when he agreed to return to school.

Jean told me Alex was in care because of his mother's attempts at suicide and he was reluctant to talk about his own problems with self-harm because he *'felt ashamed of what he was doing'*. She goes on to say *'it sounds silly doesn't it, but he was. He didn't want anyone to know that he had done it'*. Jean told me that she told the social worker, but *'he didn't want anyone else to know, that's why he wouldn't wear short sleeves'*. I checked with Jean if she thought the social worker knew about his behaviour, but she insisted that she *'had told her'*. Again I asked if she had been given an prior knowledge of his behaviour and she said *'nobody said anything.....just that he's got a lot of issues.....because that's what you tend to get thrown up'*.

Jean recalls another incident when Alex locks himself in the bathroom for 3 hours and she had to get the police to get him out. She tells me *there were razors in there, you've got to think of that at all times...you've got to be far more aware than what you would be normally'*.

Jean said that the police wanted to arrest him, but she said *'there's no need for it, he's a kid'*. She then describes how when Alex came out *'the sweat was pouring off him because he'd worked himself up that much'* and how she had to calm him down, before giving him a drink and talking to him about what had happened. Jean said to Alex *'you forced that....I had no choice because you forced that situation...so this was your fault.....you've got to take responsibility for things'*. Jean tells me the importance of not mentioning *'in case you harm yourself because you don't want to throw it in their face all the time'*. She is also keen to reassure me that once they have *'calmed down you can talk to them'*.

Jean goes on to talk about other incidents with each of the boys and how she handles them. I refocus the interview back to service and her experiences of their input in relation to these 2 specific boys. Jean said that she had not had much input from their social workers. It would appear from what Jean told me Alex had some restrictions as to where he could go and when he disregarded these Jean had to get the police out to bring him back. Jean tells me that in her experience *'I always find with Social Services, when the crap hits the fan you don't see them. Nobody dreams of picking up the phone and saying you alright?'* She goes to say that she *don't hear from them, unless you phone them you're liked dropped'*. Jean then tells me about a young girl she had living with her for 5 years who went missing for 5 days. She explained that she eventually found out where she was and *'I phoned Social Services, we were at the bottom of the road where she was. I phoned the police and we sat there for 3 hours waiting for somebody to come and nobody came. They should have been there in a flash'*.

We go back to focusing on Alex and his self-harming and Stephen's suicide behaviour. I ask Jean if anyone asked her if she was alright when she had them living with her. She tells me *'no, no'*. She tells me that *'I always try and make them feel good about themselves because I think they've had enough baggage being in care, because that's like a stigma with kids.....I do try and give them a bit of self-esteem'*.

## Findings Across the Young Peoples' Narratives

THEMES	ELEMENTS
1. The Personal Experience of Self-Harm	<ul style="list-style-type: none"> <li>• Triggers</li> <li>• Positive consequences</li> <li>• Negative consequences</li> <li>• To the outside world</li> </ul>
2. Help	<ul style="list-style-type: none"> <li>• Accessing help</li> <li>• Who helped</li> <li>• Service involvement</li> <li>• Helpful characteristics</li> <li>• Ending self-harm</li> </ul>
3. Making a Better Future	<ul style="list-style-type: none"> <li>• Knowing who can help</li> <li>• Schooling in self-harm</li> <li>• Spreading the word</li> </ul>

**Table 1**

\*2 comments added from Jean's account pertaining to the boys she fostered.

### **Theme 1: The Personal Experience of Self -Harm**

Self-harm is complex, having a number of facets that pre-dispose, trigger and maintain the behaviour. It appears from the transcripts that self-harm for the young participants has triggers that comprise of significant life events and intra and interpersonal emotional turmoil; positive consequences that help maintain the behaviour, and negative consequences that compound their difficulties. The quotes below illustrate the story being told within this theme and will hopefully provide context for self-harming.

#### **Triggers**

*"It [being bullied] weren't as bad in primary school, but it was not as bad as in high school, but it was still bad, like.....It's hard for me... like it's really hard for me to stand up for myself, I just... I didn't really stand up for myself as much. I don't really think I have the confidence, so then I always used to keep it in."* (Tina)

It could be suggested that Tina may be pre-disposed to being a target for those who like to dominate. Tina articulates her difficulty in 'standing up for herself' and her 'lack of confidence'.

*"I've actually been bullied all my life. I was bullied in primary and I had no friends and then I moved to this secondary school and I've got three close friends but the bullying carried on, but it wasn't the same people – so people must always just find faults with me."* (Nina)

*“when my nan died that really triggered me as well, even though I was so young I didn’t understand – I was 13 – that was in the same year, that’s when I picked up the blade.”* (Nina)

*“it was just sort of.. just all at once, sort of, stress from the school and then stress from people - friends being like horrible people, and then the family arguing and stuff - all just sort of came in.”* (Lizzie)

In the 4 quotes above examples are given regarding the interpersonal traumas that trigger the behaviour; the death of a significant other, being bullied and the internalisation (intrapersonal) of those experiences, stress. While each of the participants account for the onset of their self-harming behaviour, they also discuss how friends’ impact on their decision by informing them of the benefits the behaviour brings.

*“She [friend] just said that when she got.. like... it just relieved the stress. It relieves my stress but it’s just... it’s not a really good thing.. I think.. I don’t know... I mean the reason I done it was coz someone else was talking about it and saying how good it was and everything.”* (Lizzie)

*“My best friend at the time, she knew about it and she kind of triggered me into it. And then she told me everything – like how it made her feel good and obviously I wanted to feel good too, so I done the same and that’s what triggered me.”* (Nina)

### **Positive and negative consequences**

It is interesting to note that while life events may be difficult to cope with, the self-harming seems to be a choice made for the relief it brings.

*“For me, I thought it would help with... it would be a relief from basically like everything that was going on, the stress, the worry, one thing and another. It was a kind of a relief for me because it was like each cut that happened was a relief from a problem.”* (Fiona)

*“for me self-harming kind of steadied the balance out, so for me instead of not self-harming and wanting to commit suicide, it was more self-harming but still wanting to be here, because it was a relief.”* (Fiona)

Self-harm relieves internal stress, a fact well documented in the literature. Regardless of what triggered the self-harm it is maintained through its powers of relief. However, after a period of time a number of participants also talked about the negative effects of self-harming; their shame in using the behaviour;

*“Afterwards, I feel bad about what I’ve done.”* (Kim);

*“I felt ashamed.”* (Julie);

*“After the buzz had worn off with the better feeling, I felt terrible, guilty, bad”* (Nina)

*“Because he was ashamed of what he was doing at the same time. It sounds silly, doesn’t it, but he was.” (Jean)\**

### **To the outside world**

The ‘shame’ that the young people experience is also demonstrated through their beliefs about others perceived attitude towards them.

*“I’ve got quite a few friends who have self-harmed in the past and I know that when they have gone and told their parents, because people don’t really understand it, and I know their parents or other friends have said stuff like, oh, why have you done that, that’s stupid, that’s idiotic, that’s just attention seeking, because people don’t obviously see the background” (Fiona)*

*“I was thinking, what will he [GP] think, if I was going to be judged, which put me off going.” (Kim)*

*“For me, that was the big issue with everyone who I told, what are they going to say to me?” (Fiona)*

*“Cos people say, like, we do it for attention. Or if we want to kill ourselves or whatever. And we don’t. That makes people put off telling other people and getting help, in case they think that.” (Julie)*

*“I want to work with the public and with me wanting to work with the public I can’t be a danger because if I’ve got any form of mental health / self-harm issues they’re not going to have me work with the public because I could be a danger. If I’m going to harm myself, who else am I going to harm? I’d never harm anyone but like that’s the way they’d look at it.” (Nina)*

What other people think about them and their behaviour plays a central role in the data, but nonetheless it does not appear to stop them self-harming.

*“when you’re in that state of mind you don’t really know who to turn to because you don’t want to be judged by people and I think that’s a big part of it, like, young people don’t go because they feel judged about it because a lot of people... if you do speak to someone about it, they... it’s hard for them to put themselves in your shoes because they don’t know exactly what you’re feeling at that time.” (Kim)*

*“I think even to this day she [mum] doesn’t understand it completely because she was never in my shoes, she never had them thoughts herself, but she understands to the extent where she can accept it and she can help me with it.” (Fiona)*

*“He didn’t want anyone to know that he’d done it. I mean I told the social worker and that, you know, but he didn’t want anyone else to know, that’s why he wouldn’t wear short sleeves. He would wear jumpers and that.” (Jean)\**

It appears that young people are afraid to talk due to perceived stigma and a concerned they will be described as seeking attention. Such fear is restrictive both in terms of seeking help

and, in some instances, curtailing aspirations. For some of the young people the attitude they perceive others to show coupled with their original problems could lead to suicide ideation.

*“I’ve had suicidal thoughts but I’ve never carried them out or nothing, but ... I would use to think of suicide quite a lot – that was one of my main thoughts, was suicide, because it was just so easy to end it all than just carry on. Like when you really bullied that badly you just think anyway out of it ... and I had a lot of home problems going on so they didn’t help, so it was like oh yeah better off if I was gone.”* (Nina)

The young participants all experienced problems that they found difficulty talking about and turned to an alternative coping strategy as a way of self- preservation. Self-harm worked, at least in the short term. In understanding the context of self-harm these are important issues to consider.

## **Theme 2: Help**

This section, titled ‘Help’ is perhaps the longest section of this chapter as it attempts to answer a major part of the research questions giving insight into various aspects of covert and overt services that are integral to education, health and social care.

### **Accessing Services**

For a number of participants finding the courage to ask for help was problematic.

*“I tried to... like I built up the courage but then when I got to it, it had diminished, the courage, and then I’d start panicking.”* (Kim)

*“So for me it was basically just having the courage and the confidence to take that step, to tell someone, because I know I did find it hard telling her. Like I did... I did go into many meetings wanting to tell her and then ended up not saying anything and then when you do finally tell someone, it is like a relief being lifted, it is like finally happened, I can sit back and not worry as much because I know someone’s going to help me, I know someone’s going to do something.”* (Fiona)

Accessing help was also problematic in terms of not knowing where to go

*“So for me, I think without YOS I probably would have been lost because I wouldn’t have known where to go basically.”* (Fiona)

And for other participants’ access to help happened very quickly

*“I didn’t like it at all. I thought it was all too fast happening. Going too fast for me to like register what was happening. I think they [parents] went into panic mode and sort of just like, she needs help, we need to get as much as possible.”* (Kim)

In the main, participants were referred to services via their GP and it was interesting from the young person’s perspective that many saw the GP as someone who only dealt with physical

health problems, some feeling embarrassed and ashamed when going for reasons of self-harm. In addition, most participants said that their GP was not known to them as they saw a different doctor each time they attended surgery.

*“No, we have like a different one [GP] every time we go.” (Lizzie)*

*“the first connection with your GP, who’s your doctor, is when like you have a sprained ankle or when you have a cold, you don’t necessarily think of your doctor as someone who you can go and talk to about, like, problems like self-harming.” (Fiona)*

With regard to school based services, it would appear that the participants access help through teachers in more prominent positions, For example Head of Year.

*“And then the Head here signed me up for it [group counselling] well, she asked me first if I was comfortable with going and I didn’t see why not, so she signed me up for it then.” (Kim)*

Once the self-harm was out in the open, all but one of the participants had access to multiple agencies; School counselling and/or DBT skills group, CAMHS, Camouflage

*“I’ve got a counsellor from the school. I’ve had two sessions of one-to-one counselling and two sessions of the group counselling.” (Kim)*

*“We had a plan with appointments and all and they referred me to Skin Camouflage.” (Julie)*

*“They don’t all come at the same time, I go and see 2 and 1 comes to the house.” (Lorna)*

*“She [CAMHS counsellor] said that I didn’t need the counselling because I was already getting the counselling from KOOTH” (Lizzie)*

It would appear that once the participants became involved with services they began to talk to a range of people.

*“And then you get involved with more people.” (Lizzie)*

For Nina, who did not want anyone to know about her self-harming behaviour, she chose to access online services which she found very helpful.

*“But if you know there’s someone online that can listen, that can be there ... because they were definitely there, you only had to wait ten minutes for there to be a real person ... so if you know you’ve got that help instantly and you’re not waiting like weeks for the help it’s fine.” (Nina)*

### **The people who helped**

A range of people were mentioned by participants as being helpful in terms of being there, being available to talk and providing a sense of support.

*“My church pastor and my youth leader were always the kind of people who were like, great, you know we’re here for you and you know we’re here if you ever need someone to talk to or if you ever need prayer or you ever just need a listener.” (Fiona)*

*“I have got a friend that’s been a bit supportive and she’s like higher in the same group as me. She’s been supportive.” (Tina)*

*“Probably the Year Head and the Deputy Year Head, they’ve been very supportive because you can go to them at any time and they’ll just sit you down and let you talk to them.” (Kim)*

*“If it’s not, then she’ll [mum] say well come and talk to me, get it off your chest and stuff like that and we talk, and I feel a bit better because I’ve got it off my chest. Or if it’s something really bad then me parents will ring up the school and tell them.” (Tina)*

### **Characteristics of helpfulness**

For all of the young people a number of helping characteristics were important and the presence of such characteristics facilitated a positive experience of services. Helpful characteristics include; being listened to, not being judged, confidentiality, trust and opportunity to talk to somebody that is independent of family, friends or school. Confidentiality and not being judged appear to play a large part in relation to the participants feeling safe and having confidence to discuss their problems.

*“they said to me, you do know that you can tell me anything in confidence and it was like, I think it was kind of just the trigger that I needed to feel confident enough to tell her.” (Fiona)*

*“Don’t like talking about it, but I like talking to her because I know no-one else will find out, that’s one of the things they tell you.” (Julie)*

*“Probably that you don’t feel judged by them [counsellor] and that it’s confidential as well.” (Kim)*

*“So for me it was like basically knowing that she wasn’t going to stereotype me and knowing that she wasn’t going to call me an attention seeker or that she wasn’t going to think I was stupid or idiotic for doing it, that she understood that I had my reasons. So that was a help for me.” (Fiona)*

*“I felt comfortable speaking to her and I knew that if I told her she wasn’t going to be the kind of person to judge me and she wasn’t going to be the kind of person to say anything bad. If anything, she’d be there to comfort me and she’d be there to get me the help and the support that I needed.” (Fiona)*

For one participant breaking confidentiality, but only after being consulted, made it easier for her to let her mum know about her self-harm.

*“they [teacher] asked me there.. they were like do you want me to ring your Mum ... she went, oh, I don’t have to ring your Mum because it was confidential, all that, but I thought I’d*

*rather than ring me Mum than me try and tell her ... if school tell her it may be easier, and it was.” (Lizzie)*

Likewise, those attending a DBT skills group for self-harm also noted how they felt comfortable in the group because of not being judged.

*“That I’m here in a group with people who I’ve sort of seen and they’ve been going through what you’ve been through. You feel comfortable, like, talking about it, because people won’t judge us.” (Julie)*

*“If there’s people like you can speak to that you know won’t judge you because they do a similar thing, been in a similar situation and they know how it feels like, then it’s okay. Yeah.” (Kim)*

*“I’m finding it alright because there’s people around you all the same and you don’t feel like you’re the only one.” (Tina)*

For some of the participants it was also about understanding, professional expertise, the characteristics of the counsellors, including their demonstration of advocacy.

*“So I think basically, like as I said before, if you know that people kind of understand self-harming, if you know that people know what it is, then you feel a lot more confident talking to them because you know that they understand it slightly.” (Fiona)*

*“Because of his [CAMHS counsellor] attitude, for me, it was that that kind of made me realise that it wasn’t necessarily talking to a stranger about my problems, it was talking to someone who could help and that’s the difference”. (Fiona)*

*“I just need to get it off my chest and knowing that he was trained in being able to help and .....knowing that no matter what I said he wasn’t going to get up and run screaming out the room, kind of thing. He was going to say to me what’s going to support me and he was going to help me. I think just knowing that little bit of information pushes you that bit further forward to want to tell someone and to want to get help.” (Fiona)*

*“Probably being calm, the counsellors they are very calm and I think that calms you. At the same time, they are very like understanding they don’t try to jump to conclusions, because obviously they can’t do that in the job. They are caring as well. They are the main three.” (Kim)*

*“And they’re available most of the time.” (Kim)*

*“And, she seemed that bit supportive.” (Julie)*

*“It was half an hour but now she’s trying to get an hour because half an hour’s not long enough she says, and she’ll try and get me two hours a week, even if it happens on different days, coz half an hour just isn’t long enough.” (Lizzie)*

In addition to the above, some of the participants found attending a DBT skills group helpful in terms of not feeling ‘alone’.

*“Sort of like, they explain to you like you don’t have to be alone in it. So I think that’s why the group helps.” (Kim)*

*“Cos there’s more of us. And you can mix, trust them. I trust them at CAMHS but the group is a bit different because at CAMHS it’s just me and in the group they’ve all self-harmed.” (Julie)*

Only 2 participants made a comment directly related to negative experiences they had of services, both referring to people they spoke to in their respective schools.

*“She [member of staff at school] just asked me why and how and why, what’s triggered this? Was it home problems? - and most of it was ... was it school problems? It was more like brushed off because a lot of teenagers have home problems and school problems so it was like, ‘yeah, normal teenager, bye.” (Nina)*

*“Near the end I did start to speak to someone, but I never told them that I self-harmed because I knew with me being under 16 it was like yeah phone home. So I did tell them that I was depressed and I’d had these suicidal thoughts but she never said anything. She doesn’t teach or anything, she was just in her office. She was like a nurse. Like if I had broken a leg I’d go straight to her for a bandage or whatever ... if I’d cut my hand I’d go to her.” (Julie)*

One or two participants talked about strategies they found helpful.

*“writing letters to people who have hurt you and then ripping them up.” (Tina)*

*“It was like, some of the breathing helped, because it was very calming and took your mind off everything. So the stuff she learned me, I went home and done all the breathing and it takes your mind off it.” (Tina)*

*“Yeah, breathing methods, and how to get your mind clear and that.” (Julie)*

*“Yeah, they [Camouflage] help me with things, like my scars and that. They were good.” (Julie)*

## **Stopping self-harming behaviour**

Within the myriad of aspects that all contributed to the participants’ experience of being helped, it was interesting to try and pinpoint what they believed to be the reason for stopping the self harm.

*“A lot of people who do self-harm or who do feel suicidal need to know that, like, people are going to be there and not judge you. Because I know, if I wasn’t on a YOS Order personally I think I probably still would have been self-harming today, because I didn’t know about the associations that are out there to help.” (Fiona)*

*“I couldn’t stop like that ... working gradually ... I tried to wait ... like I love chocolate so if I wake up and I really want to cut that day if I wait an hour I’d have a piece or if I waited two hours ... and then I’d just ate the whole bar and I felt great ... like I was handling stopping.”* (Nina)

*“I didn’t really think it was such a big thing... I just thought it’s something I do. But then, like now, like I haven’t done it for about three weeks but like people... it’s just like now it’s just like I’m glad I’ve had all those people, a whole lot of people get involved but now I think I’m glad they got involved, otherwise I would never have been stopping... coz I needed them to stop.”* (Lizzie)

### **Theme 3: Making a Better Future**

The final theme identified across the narrative of the young people focuses on what more could be done in the future to help others who use self-harm and perhaps, more import to prevent it happening.

#### **Knowing who can help**

For some of the participants part of the problem of feeling distressed is not knowing where help can be accessed.

*“I would have basically just like to have known that there was organisations out there like Samaritans, because for me I didn’t know... I did not have a clue in the slightest. I didn’t know there was CAMHS, ... so for me, it’s basically just knowing that they are out there, whether you need them or whether you don’t need them, it’s always good to know that you’ve got people there who can help.”* (Fiona)

*“Like, just like something there for people so they know they’re not alone for the ones who are, cos like me, I thought I was alone and I was the only one, but actually I’m not. Saves keeping it in because that’s just going to make it worse.”* (Tina)

*“Yeah, because there’s not many people out there have supporting parents. So that’s another thing why you need someone there for them.”* (Tina)

*“if you’ve got a problem you kind of want to deal with it now, you don’t really want to wait.”* (Lizzie)

However, it is also important to ensure that when information is given regarding what help is available it is specific in terms of what different organisations offer.

*“don’t know... coz they said the numbers and emails, it didn’t say what they do... you know like, I don’t know if I should ring them if it’s the wrong thing”* (Lizzie)

## **What to do in school**

Overwhelmingly all participants talked of their experiences related to self-harm within the context of school and the part it played. This may well have been due to the age of the participants, with 2 recently having left school and now in college, 4 of them being interviewed in school and 6 of them having started using self-harm and accessing help whilst at school.

*“Like, use posters and put them up around schools. Obviously they’re going to be in school so if they see them around and if there’s enough of them, I think people could look at them but not draw attention to themselves and no-one... from other people... knowing them and looking at them, because then obviously things start to happen around school and you could, like, probably go into schools and do presentations on it.” (Kim)*

*“Because it’s like there’s a smoking regime at our school and that’s advertised - there’s posters all around school but then there’s nothing for like counselling anything like that so... my school, there’s more people who actually self-harm than smoke or drink.” (Lizzie)*

*“just a little card [placed discretely so can easily be taken], like makes it easier” (Kim)*

*“Maybe go into different schools and advertise it and speak to kids in the schools, for them and talk about their fears so they know.” (Tina)*

*“For someone to come in [to school] who you can talk to, they only have to be there for comfort, it’s alright. You can talk to them.” (Julie)*

*“educate kids about self-harm because... I didn’t really know about it so I thought I’ll do it once and then I’ll never do it again... thing is in our school coz no-one really knows .. none of the teachers ..... it doesn’t get mentioned so.. I know we have counselling and stuff but it feels very put away, ... even if it’s just like an hour or something, not even an hour, - maybe in Assembly.. have an Assembly about self-harming and stuff like this.. just do it!” (Lizzie)*

*“I think there’s only two [counsellors in school], and there’s really quite a lot of people who do it who need counselling, so I we need to get more helpers, at least even coming in or working in the school or even just coming in for an hour, see one person - it would just make the difference.” (Lizzie)*

*“That’s just been my experience because you’ve got like all groups and stuff like that in school, but not everyone knows there’s a counsellor in school, not everyone knows there’s help around or nothing, so that’s why you tell them you can get help.” (Lizzie)*

*“Certain teachers are more approachable then others, for certain students, anyway, so yeah, I think they should just try and be approachable for, like, don’t seem like they judge.”(Kim)*

## **Spreading the word**

Beyond the bounds of school the young participants also emphasised the need to increase knowledge about self-harm to the wider population.

*“I think because a lot of adults go to the GP, like older people, I think if they see that side of it they don’t know nothing and rush to conclusions. If they know any like person who does it, they will be sort of educated on it as well. So they know not to do certain things because it will make the person feel worse, who’s doing it.” (Kim)*

*“there should be more posters around, like you see a lot of things on the television, a lot of alcoholics – alcoholics get a lot of help, like ring AA or do this, do that – but there’s nothing like help towards self-harm.” (Nina)*

*“Yeah there should be more online based things where you can go in and just talk and everything can be confidential, unless you’re in like serious danger.” (Nina)*

*“In a way that made it more like, a supported sort of subject, because a lot of it is quite a taboo subject to be thinking about and stuff. But if they knew that it was well-known, that it actually happens, and not for there to be a taboo subject any more, I think that would help a lot of people to deal with it, and to say, oh yeah, I’m not the only one who does it. So, I think that way it would help.” (Kim)*

*“even just being able to ring someone and say, listen, I’m having thoughts of doing this, even I think a lot of people wouldn’t have self-harmed if they knew that they could speak to people before they had self-harmed when they were, say, having thoughts before they made an action, because for me if I knew that I could speak to someone in confidence and comfort about what I was thinking before I had actually done anything, then I probably wouldn’t have self-harmed.” (Fiona)*

*“I was told by a friend that it gave her stress relief, so I thought it would give me stress relief... and I think if I would have known about it in the first place then maybe I wouldn’t have started it.” (Lizzie)*

The final 2 quotes of this section of the findings highlight that fact that had they known about self-harm and help was available they might not have felt the need to initiate the behaviour.

## Findings Across The Adult Narratives

THEMES	ELEMENTS
1. The Experience of Self-Harm and Being a Mum	<ul style="list-style-type: none"> <li>• Knowing your child self-harms</li> <li>• Mother-daughter bond</li> <li>• The impact of knowing</li> </ul>
2. Help Seeking	<ul style="list-style-type: none"> <li>• Looking for help</li> <li>• Professional help</li> <li>• Support for self</li> </ul>
3. Where to go and the Future	<ul style="list-style-type: none"> <li>• Lack of support</li> <li>• Help needed</li> </ul>

**Table 2**

### **Theme 1: The experience of self-harm and being a mum**

For daughters and mums alike self-harm is a complex problem. It appears from the transcripts that mothers, one attuned to the fact that their children are using self-harming behaviour, a raft of emotions affect their own behaviour. The quotes below illustrate the story being told within this theme and will hopefully give some insight into the experiences of mothers whose children self-harm.

#### **Knowing your child self-harms**

*“Right, I know she’s cut herself once because she told me and I was just, sort of like, alright okay, don’t do it again - that was it. And then I got a phone call about a month later off the school, saying that have I seen her cuts and I said no. And she’d done them the night before and they were all on her arm and all on her leg, and that was the first I sort of really knew - I thought she’d just gone like that and cut herself at the same time but this was really bad, and that was the first I heard.”* (Valerie)

*“And she’s quite level headed so it really shocked me, that, because she is quite level headed... I don’t know ... well out of my league!”* (Valerie)

*“I just couldn’t come to terms with the fact of why she’d done it and she said to me I’ve just got so many things going on in my life...you don’t need to know. I said well truly I do, because I’m your mum. I said I should be able to help you and if I can’t help you, I said, I should be able to find somebody that can.”* (Linda)

While Valerie is ‘shocked’ by Lizzie’s behaviour, Jean, in the 1st quote below, talks about how, as a mother, you instinctively know something is wrong. In the 2<sup>nd</sup> quote she tries to articulate what might underpin that ‘gut feeling’.

*"I said, I know why you won't go to school and he said, why, and I said you've come out on [internet] haven't you, that you're gay, and he went, how did you know? But you know, when you have a gut feeling, you do get gut feelings, just like you would with your own, it's amazing and I just knew."* (Jean)

*"I mean I know all kids are different, but you can tell when there's something up and they... because he would only give you a little tiny bit of information or he would say... what, you know, and I would try and encourage him to talk because I think if you encourage them to talk it helps a bit, doesn't it, if there's something on their minds."* (Jean)

Knowing that self-harming behaviour is being used, as parents they feel a responsibility to do something about it.

*"I can't let this go, I said to her, because I said if I do then other people notice it they are going to say well, what's your mum done about it? You know, I said, so it needs to be cleared, it needs to be sorted out."* (Linda)

*"I said you've got to take responsibility for things that you do and that was silly. I said the reason I had to get the police out was because you wouldn't come out [locked himself in the bathroom] and I didn't say, in case you harmed yourself because you don't want it thrown in their faces all the time, do you."* (Jean)

*"The first time she told me, it was only like a little cut that - do you know what? My alarm bells should have rung then... I didn't know that all the weeks later she'd be cutting and cutting and cutting and cutting... well... I'll learn and I'll work, and I do look now and I will look now"*. (Valerie)

### **Mother-daughter bond**

Valerie's and Linda's transcripts demonstrate a strong bond between mother and daughter.

*"It took a while for us to get into CAMHS, sort of thing, but yeah we did, we eventually got into CAMHS and we spoke to different people in CAMHS and then we got therapy through CAMHS."* (Linda)

*"She put her at ease and that's the main thing isn't it ... Because it must have - it's hard... it's hard for me but I also look at it's hard for her because it's like confusing anyway as it is."*(Valerie)

*"I think we were with a counsellor maybe two or three months, something like that, altogether."* (Linda)

In each of the 3 quotes above there is a melding of mother and daughter, Linda's use of 'we', Valerie's symbiosis, hard for me, hard for her. Valerie goes on to offer insight in to why she found it 'hard' and how Lizzie is 'now on the road to recovery' and she is 'back to normal'.

*"And when she was sitting there and I went you need to get some sterilised pads and she sat there and ... it's scary when it's like yours - it's different if it's somebody else."* (Valerie)

*“Because I think she’s on the road to recovery, I’m quite happy - I was treading on eggshells for a bit, I’m not now, I’m back to normal.”* (Valerie)

One explanation for such strength of bonding could be the absence of both girls’ fathers in terms of their self-harming behaviour. While Lizzie’s dad appears unable to accept that there is anything wrong, Fiona’s dad has serious health problems which often create an absence through admission to hospital and/or himself being in need of a lot of care.

*“And her Dad didn’t believe it, he was not having it. so... we’ve had that battle.”* (Valerie)

*“With everything that’s been going on with her dad and one thing and another, you tend to put things on back burners but I was also trying to keep on top of her and keep on top of her dad.”* (Linda)

### **The impact of knowing**

When considering the role of being a mum, the closeness of the mother-child relationship and learning about your child’s self-harm, the impact on self can be far reaching. It appears from the data that there is an emotional and behavioural impact, the former related to fear and the latter to testing of boundaries.

*“It really worries me, I don’t know why, it just does. I’m just scared in case it goes on to something else, and that’s me worry. Because once they start cutting they can do anything else can’t they? She could kill herself, she could do anything - it’s worrying isn’t it?”* (Valerie)

*“it’s my daughter - it really frightened me. Really, really, really frightened really, I thought Jesus.”* (Valerie)

*“I just didn’t think it was ... I don’t know what I thought.. I was just... I went wow...oh god...I was shocked [seeing scars].”* (Valerie)

Being fearful for their daughters appears to initiate doubts of their ability as a mother.

*“I dunno.. but no-one sort of gives you a book to say this is what happens and you’ve got to... if, like this self-harming - you don’t know if you’re doing good or bad as I say - giving her leeway or not giving her leeway.”* (Valerie)

*“And it frightened me a bit because I thought, well, am I doing the right thing.”* (Linda)

*“It’s hard trying to understand”* (Linda)

*“I feel horrible saying that, I don’t mean - because she goes dancing and she goes doing stuff, why do you cut yourself - why? Why mark yourself like that?”* (Valerie)

*“I just couldn’t come to terms with the fact of why she’d done it.”* (Linda)

*"I don't want just to leave it to her.. and ... I come home doubting myself, I don't know... I'm a bit nervy if it's something I've done or is it... coz she goes it's not your parenting skills because we're quite - as I say, we're open, if there's a problem we're open to it.. but I just... it's only - I think this is the first time that I've spoke to you that I haven't heard - coz all I do is cry, every time I mention it."* (Valerie)

The impact of knowing also has the potential to change a person's behaviour.

*"Like if he was upstairs for a while I would come to the bottom of the stairs and say, are you alright? And he'd go, yeah, I'm just tired. Okay, are you sure you're alright? Yeah."* (Jean)

*"he shouted his head off, screaming at the top of his voice, leave me alone, and I'm like, there was razors in there, you've got to think of all that all the time, you've got to be far more aware haven't you than what you would normally."* (Jean)

*"But I was scared. I was pussy-footing around at first and maybe you're right, maybe you do need to sort of go somewhere and see, because you don't know what you're dealing with."* (Valerie)

The data also suggests that as a mother you introduce censorship in who you might speak to about the self-harm.

*"But, as you say, there's only certain people that you can relax and talk to about. We have got other friends, but I wouldn't go to them and discuss Fiona with them because they're just... they are the type of people you can but you can't, if you understand what I mean."* (Linda)

*"But also, I told him [dad] because I was scared in case anything else happened - if she had done something really bad in my head and so... and I thought it'll be on my conscience forever and I was sorry I told him, so I shouldn't have done that... but I did."* (Valerie)

*"I hate talking about it, I do, I hate it."* (Valerie)

*"I think it's also a thing that teenagers learn isn't it?"* (Linda)

## **Theme 2: Help Seeking**

This next theme considers how as mothers they sought help for their daughters' self-harm and what help they found both for their daughters and themselves.

*"it didn't matter about the doctor or dealing with anyone, it was more to get her help, I didn't care who I went to".* (Valerie)

*"It's obvious, I said, you need some sort of help. I said you can't talk to me about your problems, for some reason I don't know, you obviously need to talk to outside people."* (Linda)

## Professional help

Both mothers on finding out about the self-harm approached their GP.

*“And they just referred her - he [GP] didn’t ask to see her scars or nothing, or where she’d cut, he just was asking a few questions - sorry - he was asking a few questions and then he referred her and it was quite quick. She got done, referred quite quick so she’s been there now.”* (Valerie)

*“So the first port of call you obviously think, your doctor. I spoke to the doctor and said to the doctor that I’d found out she was self-harming and the doctor said we need to get in contact from CAMHS. He said to try and find out why she is doing it.”* (Linda)

In terms of other services, both Valerie and Linda appeared to have had positive experiences.

*“The school’s quite a good school. They seem to - if anything’s wrong or anything like that, they get in touch with you. They’re quite good.”* (Valerie)

*“She [YOS worker] comes out and like I say she’s helped with the parenting issues... I went on a parenting course and completed that and I know she’s always been on the end of the phone sort of thing.”* (Linda)

*“When I’ve been a bit concerned about anything and they’ve dealt with it and they’ve [YOS] got back to me.”* (Linda)

*“A really nice girl - they [Camouflage] were like youngish girls so it was good, yeah. They’re really, really, really good they were. They were also talking to her constantly about it - she goes dancing and then they were really... and she was like dead at ease - I just sat back and watched - it was lovely.”* (Valerie)

However, not all their experiences have been positive.

*“They [CAMHS] rang me fairly quickly and said, yep, we will book Fiona in and I think they seen us within a couple of weeks and then... or did we wait about six weeks, I think we waited about six weeks, but we did have to keep on top of them.”* (Linda)

*“You have to go and find them for yourself. ....you’ve got to go and do everything yourself because nobody tells you anything.”* (Linda)

*“I always find with Social Services, when the crap hits the fan you don’t see them. Nobody dreams of picking the phone up and saying, you alright? Unless you phone them, you’re like dropped.”* (Jean)

*“so it was a real shock... she [counsellor] said... it’s her gets on her nerves and I spend too much time on her, and you know what, I couldn’t say it was wrong, she was wrong - and I was going ... I don’t know... and then I was going, oh, is it my fault?”* (Linda)

*“I had spoken to people about Fiona in CAMHS sort of thing, her case worker and then she also said to me, are you okay, and they basically just told me... they gave me advice about sort of what to do at home, in other words make sure there’s no belts around, make sure*

*there's no razors around, like Peter's razors or whatever. Try and put them all away. So I did."* (Linda)

*"No, no, just that he's got a lot of issues.... because that's what you tend to get thrown up."* (Jean)

*"I said there's no need for that. We'll [police] arrest him. I said there's no need for it, he's a kid, I just wanted you to get him out the bathroom."* (Jean)

*"Apart from when this lady first rung - she rung up and said she's been cutting herself with a knife - those were the words I heard... scary."* (Valerie)

The quotes above represent a number of concerns ranging from; unacceptable behaviour on the part of professionals, police wanting to make an arrest, social worker not being available when problems are happening; ill-informed communication, 'cutting herself with a knife, telling (advice) to put dangerous instruments away, mother-blaming; waiting times and information not being readily available. However, in the main comments regarding professional help were positive.

### **Support for self**

Integral to seeking help is that of support for self. The quotes below offer insight into the support Linda and Valerie established for themselves.

*"He [minister] rings me up and he'll come round every now and again and he'll say, is everything okay, look you know I'm only on the end of the phone if you want me, sort of thing, you know. Don't hesitate to ring or even just send a text message and I'll come round, sort of thing. But, yeah, he's always been there on hand, sort of thing, for us."* (Linda)

*"But she [Friend] always says to me even if you just want someone to talk to, even if you don't want to come round, we can make arrangements and just go for a cup of coffee, and I've done that a few times."* (Linda)

*"I talk to me friend about it but that's it. And she [Lizzie] wasn't happy that I told me friend - I said, oh, I had to tell me friend, I need someone to talk to. You do though, don't you though?"* (Valerie)

### **Theme 3: Where To Go and The Future**

Although both Linda and Valerie did establish support for themselves, both raised the issue of not knowing where to go for more formal support.

*"I would probably have said yes [to the question would you like help?] but then you think to yourself, where do you go for the help?"* (Linda)

*"Can I talk to anyone? I don't know."* (Valerie)

*“You know, they would have put me in touch with somebody within the society [RNIB] who I would have been able to go to talk about maybe what’s gone on with Fiona or various problems that I have, you know. Its knowing who to contact.” (Linda)*

*“You know, when you are in a situation you probably think, well, yeah, I will. You think, who do you say it to? And as you say, it’s not until after the event that you realise that there’s more help out there, sometimes it’s just accessing the help and where to find it sort of thing. You have to go and find them for yourself.” (Linda)*

*“Maybe if they did something in school, I know there was a counsellor - I know there is, well she did go to the counsellor and this teacher had told me, that she’d sort of told and I thought... but I just want to know what the sort of route are.” (Valerie)*

Linda acknowledges that although she has involvement with charitable organisations she is still unsure of where to access help with the problem of Fiona’s self-harm. More importantly perhaps is the last statement that it is only ‘after the event’ that what help is available becomes known. In terms of the future this may well be worthy of consideration. In addition, Valerie, like most of the young participants, would like to see more action in schools.

*“I think they should teach these kids when they get to 10 and 11.” (Valerie)*

*“There is a counsellor at school, I know that, you can go to them because I know they’ve got a smoking woman and everything in school, haven’t they?” (Valerie)*

*“Hopefully you can get information in schools.” (Valerie)*

## Discussion

The findings from this study reiterate the complexity of self-harm, particularly with regard to young people and their help seeking behaviour. In keeping with other research findings there appears to be a number of facets that pre-dispose, trigger and maintain self-harming behaviour. Trigger factors include bullying, significant life events, such as someone close dying, family and/or school problems (Fox & Butler, 2007). In addition to such triggers accounting for the onset of their self-harming behaviour, evidence in this study implicates friends' in the decision-making to use self-harm as a coping strategy by informing those who might be vulnerable of the benefits the behaviour brings. This finding is in keeping with Fortune et al.'s (2008) findings, as is using self-harming behaviour as a way of achieving immediate relief from the internal stress experienced as a consequence of the above difficulties (Hill, 1999; Storey et al., 2005; Fortune et al., 2008). Such immediate relief, particularly though use of cutting is powerful in terms of maintaining the behaviour. Perhaps realising the potential self-harm has as a coping strategy should help inform how important it is that alternative approaches for coping with stress need to be known, understood and made readily accessible to young people.

While the findings in this study provide some information regarding triggers and the positive effects of self-harm in relation to these, some of the participants also highlighted the longer term negative consequences. After a period of time a number of participants experienced shame that they associate with the behaviour. It would appear that their 'shame' centres on their belief about how others perceive them (Le Surf & Lynch, 1999; Fox & Butler, 2007; Fortune et al., 2008). Despite this being a concern for the young people, it can also be seen as a maintaining factor in that it perpetuates their negative feelings about self, creating further anxiety and the need to punish self (Skoogman, 2003; Holden & Delisle, 2006; Scoliers et al., 2009). The perceived stigma also complicates the help seeking process, making young people afraid to talk about their problems (Fox & Butler, 2007; Fortune et al., 2008). One example in this and other studies is that of feeling embarrassed in seeking help from their GP (Buston, 2002; Roose & John, 2003), while another example is that of being labeled attention seeking (Fortune et al., 2008). For some of the young people not being able to talk about their problems only made them worse and this situation has the potential to lead to suicide ideation.

A number of studies have highlighted the dilemma young people have about sharing their problems with other members of their family (Roose & John, 2003; Fortune et al., 2008). Such concerns include; issues of being open in front of parents, a sense of protectiveness and worries regarding parental reactions and causing hurt to those they care about (Street &

Svanberg, 2003; Hart et al., 2005; Street et al., 2005; Day et al., 2006; Fortune et al., 2008). All these issues were born out in this study. Some of the girls did not want to worry their mother, while others identified the trigger as being family problems and therefore perhaps inappropriate to broach with parents (Fox & Butler, 2007). However, further difficulties arise in knowing who to turn to regarding problems and perhaps more importantly who they can trust in terms of confidentiality. Knowing that the person who they told about their self-harming behaviour would treat it as confidential information was extremely important for all the young participants. A finding consistent with a number of other studies (Le Surf & Lynch, 1999; Howieson & Semple, 2000; Pope, 2002; Roose & John, 2003; Fox & Butler, 2007), confidentiality appeared to play a central role in disclosing their self-harm. Regardless of being told that certain things would have to be reported to other agencies, the young people in this study still felt reassured that disclosure of self-harming would be kept confidential, and for some, knowing this facilitated finding the courage to tell.

The difficulties regarding who to tell cannot be ignored and thought needs to be given as to the fine line between providing sensitive confidential help to young people whilst at the same time considering support that their parents/family might require. While it has been argued that parents and/or guardians are best placed to spot signs of distress and/or self-harm, the mothers of those participating in this study found out about the behaviour through their daughters' telling them directly or via their school. In a study by Oldershaw et al. (2008) it was found that although parents often spot signs of self-harm early they struggle to understand and cope with self-harm. For the two mothers interviewed, a mix of fear and shock could have acted as a barrier to understanding and coping with the behaviour. Indeed being fearful for their daughters' wellbeing appeared to initiate doubts of their abilities as a mother.

For both sets of participants accessing help was problematic; a lack of knowledge re where to go for help was report by adults and young people alike (Fox & Butler, 2007). Additionally, a lack of confidence and courage also impeded some of the young people accessing help. With regard to the latter, the evidence suggests that once the young person was engaged in regular meetings with an adult confidant they eventually found the courage to reveal their self-harming behaviour. This is problematic, as for this to occur it is implicit that behaviour warrants input has already started, whereas it might be more productive to ensure help is available before the onset of self-harming behaviour. Likewise, and with regard to the former, young people and their parents/guardians need to have knowledge about where they can access appropriate help.

For some of the participants it was teachers who initiated discussion either directly about self-harm or indirectly about their emotional wellbeing. While it is suggested teachers are not appropriate to take on the role of counsellor (BACP, 2001; Roose & John, 2003; Fox & Butler, 2007), the role they played for participants in this study was pivotal in them accessing appropriate services. Once the participants became involved with services they began to talk to a range of people from a variety of services. A number of helping characteristics were important to the participants, and the presence of such characteristics facilitated a positive experience of services (Hart et al., 2005; Storey et al., 2005). Helpful characteristics included; being listened to, not being judged, confidentiality, trust, opportunity to talk to somebody that is independent of family, friends or school, understanding, and professional expertise. Some of these characteristics are in keeping with what is deemed to be good practice within the NSF (2004).

The personal characteristics of the counsellors, including their demonstration of advocacy, were also important to both groups of participants. All but 1 of the young participants suggested face to face support was their preferred option (Roose & John, 2003), and for 6 of them they had been able to access this through school. Counsellors from Kooth, a local organisation, provided both 1 to 1 counselling and DBT skills groups within various schools. However, some of the participants felt more counselling support was needed in schools, a proposition supported in the literature (Baruch, 2001; Hartley-Brewer, 2001; Burns & Rapee, 2006). The DBT skills groups were a particularly effective outlet for the young people, the main function being interpreted as mediating the feeling of being 'alone' and providing knowledge of not being the only one who has or uses self-harm as a way of dealing with difficulties. Whilst the stigma attached to self-harming behaviour did nothing to stop it, importantly being involved with various services and the attunement of those delivering them did facilitate the end of the behaviour. Again this is an area that needs to be captured and extended in order to promote the prevention of self-harm.

When considering the above, it is obvious that there is a gap between problems arising and the referral to a range of services. For most of the participants in this study the gap can, to an extent, be bridged by school. Overwhelmingly all participants talked of their experiences related to self-harm within the context of school and the part it played. While this report does not advocate that teachers act as counsellors, they do need to be sympathetic and empathic in terms of the children in their care and the problems they face. In keeping with other available research an independent counselling service readily available to all children and young people in the educational system would be of great benefit (Pope, 2002; Roose & John, 2003; Cooper, 2004; NSF, 2004; Fox and Butler, 2007). However, school is well placed to address the emotional needs of the age group when the onset of self-harm is most

likely to occur. All participants wanted more knowledge about self-harm via informative assemblies and posters being placed around school that are integral to other public health alerts, for example stopping drinking, smoking, etc. Beyond the bounds of school both groups of participants, emphasised the need to increase knowledge about self-harm to the wider population, in the hope of making serious inroads into this risky and yet unnecessary behaviour that more of our children and young people are turning to.

### **Limitations of the study**

One of the limitations of this study is that all the participants are female. With regard to self-harm boys are often referred to as a hidden population and it is mirrored in this study. As suggested earlier, recruiting to the study was difficult and this may have been due to the sensitive nature of the topic and/or the shame that appears to be integral to self-harming behaviour. While these could be reasons for the small numbers recruited, the issue of shame and the social stigma attached to talking about emotions have been cited in the literature as being more problematic for boys and could have impacted on the recruitment of males to this study.

## Conclusion

This research project was insightfully commissioned as part of a multi-phase workforce development project. Its insightfulness relates to the uniqueness of the project, there being no other studies undertaken that explore the views of young people and parents/guardians of young people regarding support for those who self-harm and/or have suicide ideation. In returning to an earlier section of this report, '**Involving young people**', having listened to the young people and the parents/guardians of young people who self-harm it is important that their voice is heard and appropriate changes in practice are made. While the number of participants is limited, they do form part of the local community and have given a depth of knowledge that has the potential to contribute to the effective delivery of the Knowsley Emotional Well-being Strategy.

## Recommendations

1. To action the findings of this study
2. To support a campaign in schools that highlights self-harm as a serious health topic; gives insight and understanding into the behaviour and provides knowledge of available help.
3. To educate and train those professionals most likely to come into contact with young people and the parents/guardians of young people who use self-harm.
4. To consider how counselling within schools and other age appropriate places for young people can be extended.
5. To instigate the developments of support networks for the parents/guardians of young people who use self-harming behaviour.
6. To undertake further research specifically aimed at males who self-harm and male parents/guardians of young people who self-harm.
7. To explore the role of social media in relation to self-harm within this age group.

In keeping with the spirit of the report the last word is given over to Fiona

**“just basically a thank you for the organisations that are out there that do help, because without them God knows where I’d be.....but you just do need to get the word out a bit more”**

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Appendix 1

# Knowsley Self Harm Project

## We want to listen...



**Knowsley have asked researchers from Salford University to talk to young people in confidence about their experiences of self harm, services and their ideas of how we can improve things**

**Do you want to be involved in the improvement of self harm related services for young people like yourself?  
Please text or call Sue on 07733060960, or visit  
[www.shout4knowsley.com](http://www.shout4knowsley.com) for more details**

# **Knowsley Self Harm Project**

## **We Want To Listen**

**Knowsley have asked researchers from Salford University to talk to young people in confidence about their experiences of self harm, services and their ideas of how we can improve things.**

**If you would like to be involved then please text or ring Sue on 07733060960 or visit [www.shout4knowsley.com](http://www.shout4knowsley.com) for more details**

University of  
**Salford**  
MANCHESTER



## Appendix 3



School of Nursing, Midwifery & Social Work  
University of Salford  
Salford, Greater Manchester  
M6 6UP United Kingdom  
Tel: 07733060960  
E-mail: s.mcandrew@salford.ac.uk

Date 12.11.12

Dear ,

### **Invitation to participate in research study**

My name is Sue McAndrew and I am researcher at the University of Salford, and I have been asked by Knowsley Children and Young People's Commissioning Team to do a research study to find out what young people who self-harm or who have felt suicidal would like from nurses, doctors, teachers, social workers and other people to make their life happier.

With this letter is an information leaflet that tells you more about the study and what you will be asked to do if you want to take part. Please read the leaflet and if you think you would like to talk to one of the researchers about your experiences of what help you have received when you have self-harmed or when you felt life was really bad please phone or e-mail me, the number and e-mail are at the top of this letter or if you want you can ask an adult you trust to contact me for you.

Once you have contacted me and have had any questions you had answered you can then decide if you want to take part.

If you decide to take part in the research a researcher will meet with you and ask you about your experiences and if you agree the session will be tape recorded.

We want you to know that what you tell the researcher will be kept confidential and the researcher will call you by a different name of your choice and will make sure you do not say anything that would let anyone know your identity. The only time the researcher would have to tell someone else who you are is if you tell the researcher about anything that is not legal.

If you are interested, please get contact me yourself or through an adult

**Thank you**

Yours sincerely

Sue McAndrew

(version 1.0: 18.9.12)

## Appendix 4



School of Nursing, Midwifery & Social Work  
University of Salford  
Salford, Greater Manchester  
M6 6UP United Kingdom  
Tel: 07733060960  
E-mail: s.mcandrew@salford.ac.uk

Date 12.11.12

Dear ,

### **Invitation to participate in research study**

My name is Sue McAndrew and I am researcher at the University of Salford, and I have been asked by Knowsley Children and Young People's Commissioning Team to do a research study to find out what guardians of young people who self-harm or who have felt suicidal would like from statutory and non-statutory services (schools, hospitals, social services, voluntary services, etc.). Knowsley Children and Young People's Commissioning Team are hoping by researchers talking to guardians of young people and finding out what they have needed and would like in terms of support, that they will be able to improve the current services.

Enclosed with this letter is an information leaflet that tells you more about the study and what you will be asked to do if you want to take part. Please read the leaflet and if you feel that you would like to talk to one of the researchers about your experiences of what help you have received when your child has self-harmed or been suicidal please phone or e-mail me, the number and e-mail are at the top of this letter. Once you make contact please ask as many questions as you want and I will attempt to answer them, before you decide to participate.

If you decide to take part in the research a meeting at an appropriate venue will be set up between you and the researcher and if you agree the session will be tape recorded. What you tell the researcher will be kept confidential and the researcher will call you by a different name of your choice and will make sure you do not say anything that would reveal your identity during the session. The only time the researcher would have to tell someone else who you are is if you tell the researcher about anything that is illegal.

If you are interested, please contact me via phone or e-mail

**Your help would be greatly appreciated**

Yours sincerely

Sue McAndrew

(version 1.0: 18.9.12)

## Appendix 5



### Participant Information Sheet – Young People

**Title: Self-Harm and Suicide in Knowsley: An exploration of what young people and guardians of young people who self-harm and feel suicidal think they need in terms of help and support.**

#### INVITING YOU TO HELP US

We are trying to find out about young people's views of the help available for those who self harm or have felt suicidal at times during their lives. It would be really good if you would feel able to talk to a researcher about your experiences of such help or why you decided not to seek help. Before deciding if you would like to help or not please take time to read rest of this leaflet and if you wish discuss taking part with others.

#### WHAT IS THIS STUDY ABOUT?

- It is about getting the views of young people (under 18) and guardians of young people who self-harm and/or have felt suicidal, about what help they have found or think would be helpful.
- If you are a young person and you have self-harmed or felt suicidal and you feel that you would like to talk to a researcher about your experiences of services we would like to hear from you.

#### WHAT IS THIS STUDY HOPING TO DO?

- To listen to the stories of young people who have self-harmed or who have felt suicidal about the services they have used to get help or to find out why they have not used services.
- To listen to the stories of guardians of young people who self-harm or have felt suicidal to find out their experiences of trying to get help for their son/daughter.
- To find out what each of the above groups want from professionals and services to prevent the use of self-harm and feeling suicidal and to improve their emotional wellbeing.
- To use the findings to improve services in Knowsley.

#### DO I HAVE TO TAKE PART

- No you do not have to take part. If you decide that this is not for you it will not affect you or your family in any way.

#### BEFORE PARTICIPATING IN THE RESEARCH

- Once you have read this leaflet you can contact the researcher to ask questions about the research.
- When all your questions have been answered you can think about whether or not you want to participate.
- If you are happy to participate you and the researcher can arrange a convenient time and place for the interview to take place.

- At any time you can change your mind and withdraw from the study. Any help or support that you and/or your family are receiving will not be affected in any way should you not wish to participate.

#### WHAT WILL HAPPEN DURING THE RESEARCH?

- Before being interviewed you will be asked to sign a consent form. If you wish, the form will be explained to you so that you are clear about what you are agreeing to do. If you are under 16 your parent/guardian will also be asked to sign the form.
- The researcher is interested in hearing what you have to say and your views about what you believe would be of most help when you have self-harmed or felt suicidal. If you agree the interview will be audiotaped.
- During the interview the researcher will be careful not to use your real name (an agreed name prior to the interview starting can be used if you prefer) or the names of people or places that might identify you.
- The interview will last no longer than 60 minutes and what is said will remain confidential between you and the researcher, unless you declare anything that is illegal, which the researcher is duty bound to report.
- At the end of the interview the audiotape will be turned off and there will be some time for you to talk about any parts of the interview you found upsetting or difficult. This information will not be included in the research.
- You will be free to end the interview at any time. If you do decide to no longer participate in the research the information you have given to the researcher will be destroyed and not used in the research.
- At the end of the interview you will be given a £10 voucher for taking the time to participate in this research.

#### WHAT HAPPENS AFTER THE INTERVIEW

- The researcher is hoping to interview 10 young people and 10 parents/guardians of young people who have or do self-harm or have or do feel suicidal.
- Once the interviews are complete the tapes will be sent to a firm used by the university, for transcription. Before going the researchers will ensure there is no identifying information on the tapes.
- Once the tapes and transcriptions are returned, the researchers will analyse what has been said by each person participating in the research and will then look at all the transcripts to see what similarities and difference there are.
- Once this work is complete the researchers will write a report for Knowsley and all information in the report will be anonymised.

#### CONFIDENTIALITY

- As stated above what is said will remain confidential between you and the researcher, but we must highlight that if you do tell the researcher anything that is illegal, the researcher is duty bound to report it to the appropriate authorities.

#### WHAT ARE THE BENEFITS OF PARTICIPATING IN THE RESEARCH

- By talking about your experiences it is hoped that the services in Knowsley for

young people who self-harm or feel suicidal will be improved.

#### WHAT ARE THE DRAWBACKS TO PARTICIPATING IN THE RESEARCH

- Talking about your experiences might be distressing. At the end of the interview the researcher will turn off the tape recorder and provide an opportunity to talk about any aspects of the interview that you found distressing. This will not form part of the research.
- If you feel that you would like further help the researcher will be able to direct you to appropriate services that you can choose to contact.

#### MAKING A COMPLAINT:

If you wish to make a complaint about the research you can contact:

Professor Tony Warne – Associate Dean Research; Phone No. 0161 295 2777; e-mail [a.r.warne@salford.ac.uk](mailto:a.r.warne@salford.ac.uk)

OR ask an adult you trust to make the complaint for you

#### WHAT NEXT?

- Take the information leaflet and think about participation, contact details are written at the bottom of this sheet if you want more information.
- If you are unsure about taking part, talk to someone you trust and feel will be able to help you make a decision as to whether or not you should participate.

Researcher's name: Sue McAndrew  
Phone number: 07733060960  
E-mail: [s.mcandrew@salford.ac.uk](mailto:s.mcandrew@salford.ac.uk)

**Thank you for taking time to read this leaflet.**

(version 2.0: 26.10.12)

## Appendix 6



### Participant Information Sheet - Adult

**Title: Self-Harm and Suicide in Knowsley: An exploration of what young people and guardians of young people who self-harm and feel suicidal think they need in terms of help and support.**

#### INVITING YOU TO HELP US

We are trying to find out about young people's and the guardians of young people views of the help available for young people who self harm or have felt suicidal at times during their lives. If you feel able to talk to a researcher about your experiences of such help or why the young person you care for decided not to seek help we would like to invite you to participate in the study. Before deciding if you would like to help or not please take time to read rest of this leaflet and if you wish discuss taking part with others

#### WHAT IS THIS STUDY ABOUT?

- It is about getting the views of young people (under 18) and guardians of young people who self-harm and/or have felt suicidal about what help they have found or think would be helpful.
- If you are the parent/guardian of a young person who has or does self-harm or has felt suicidal and you feel that you would like to talk to a researcher about your experiences of services please read the rest of this leaflet.

#### WHAT IS THIS STUDY HOPING TO DO?

- To capture the stories of young people have self-harmed or who have felt suicidal with regard to services they choose or do not choose to use.
- To capture the narratives of guardians of young people who self-harm or have felt suicidal with regard to their experiences of available services.
- To establish what each of the above groups want from professionals and services to prevent the use of self-harm and feeling suicidal and to improve their emotional wellbeing.
- To use the findings to inform and improve future services in Knowsley.

#### DO I HAVE TO TAKE PART

- No you do not have to take part. If you decide that this is not for you it will not affect you or your family in any way.

#### BEFORE PARTICIPATING IN THE RESEARCH

- You will be given information as to what you will be expected to do if you decide to participate in the research. Once you have read the information (this leaflet) there will be opportunity for you to contact the researcher to ask questions about the research.
- If you are happy to participate, you and the researcher can arrange a

convenient time and place for the interview to take place.

- Any care that you and/or your family are receiving will not be affected in any way should you not wish to participate.

#### WHAT WILL HAPPEN DURING THE RESEARCH?

- Before being interviewed you will be asked to sign a consent form. If you wish, the form will be explained to you so that you are clear about what you are agreeing to do.
- Once you have given written consent the researcher will start the interview by asking you to talk about your experiences of the help you have had for your child who self-harms and/or has been suicidal. The researcher is interested in what you have to say and your views about what you believe would be of most help when you have been or are in these situations. With your permission the interview will be audiotaped.
- During the interview the researcher will be careful not to use your real name (an agreed name prior to the interview starting can be used if you prefer) or the names of people or places that might identify you.
- The interview will last approximately one hour and what is said will remain confidential between you and the researcher, unless you declare anything that is illegal, which the researcher is duty bound to report.
- At the end of the interview the audiotape will be turned off and there will be some time for you to talk about any aspects of the interview you found upsetting or difficult. This information will not be included in the research.
- You will be free to terminate the interview at any time. If you do decide to no longer participate in the research the information you have given will be destroyed and not used in the research.
- At the end of the interview you will be given a £10 voucher for taking the time to participate in this research.

#### WHAT HAPPENS AFTER THE INTERVIEW

- The researcher is hoping to interview 10 young people and 10 parents/guardians of young people who have or do self-harm or have or do feel suicidal.
- Once the interviews are complete the tapes will be sent to a firm used by the university, for transcription. Before going the researchers will ensure there is no identifying information on the tapes.
- Once the tapes and transcriptions are returned, the researchers will analyse what has been said by each person participating in the research and will then look across all the transcripts to see what similarities and difference there are.
- Once this work is complete the researchers will write a report for Knowsley and all information in the report will be anonymised.

#### CONFIDENTIALITY

- As stated above what is said will remain confidential between you and the researcher, but we must highlight that if you do tell the researcher anything that is illegal, the researcher is duty bound to report it to the appropriate authorities.

### WHAT ARE THE BENEFITS OF PARTICIPATING IN THE RESEARCH

- By talking about your experiences it is hoped that the services in Knowsley for young people who self-harm or feel suicidal will be improved.

### WHAT ARE THE DRAWBACKS TO PARTICIPATING IN THE RESEARCH

- Talking about your experiences might be distressing. At the end of the interview the researcher will turn off the tape recorder and provide an opportunity to talk about any aspects of the interview that you found distressing. This will not form part of the research.
- If you feel that you would like further help the researcher will be able to direct you to appropriate services that you can choose to contact.

### MAKING A COMPLAINT:

If you wish to make a complaint about the research you can contact:

Professor Tony Warne – Associate Dean Research; Phone No. 0161 295 2777; e-mail [a.r.warne@salford.ac.uk](mailto:a.r.warne@salford.ac.uk)

### WHAT NEXT?

- Take the information leaflet and think about participation, contact details are written at the bottom of this sheet if you want more information.
- If you are unsure talk to someone you trust and feel will be able to help you make a decision as to whether or not you should participate.

Researcher's name: Sue McAndrew  
Phone number: 07733060960  
E-mail: [s.mcandrew@salford.ac.uk](mailto:s.mcandrew@salford.ac.uk)

**Thank you for taking time to read this leaflet.**

(version 2.0: 26.10.12)

Appendix 7

**Knowsley Young Person's Consent Form**

**Project Title: Suicidality in Knowsley: An exploration of what young people and guardians of young people who self-harm and feel suicidal think they need in terms of help and support.**

***Please tick the appropriate boxes***

**Yes No**

**Taking Part**

I have read the information sheet and been able to ask questions about the research. All my questions have been answered satisfactorily.

I understand that if I agree to be interviewed I can have a friend or family member with me.

I agree to take part in the study which will include being interviewed and this will be audio recorded.

I understand that my taking part is voluntary and I can withdraw from the study at any time without giving any reasons for why I no longer want to take part, and it will not have any effect on mine or my family's care

If I do decide to withdraw I understand that the information I have given will not be used in the research.

**Use of the information I provide for this project only**

I understand that my personal details will be kept confidential and no-one outside of the research team will know who I am

I understand that my words may be anonymously quoted in articles in professional magazines, reports, web pages, and conference presentation

**Name of young person.....**

**Date.....**

**Name of guardian .....**

**Date**

**Name of researcher.....**

**Date.....**

(version 1.0: 18.9.12)

Appendix 8

**Knowsley Adult Consent Form**

**Project Title: Suicidality in Knowsley: An exploration of what young people and guardians of young people who self-harm and feel suicidal think they need in terms of help and support.**

*Please tick the appropriate boxes*

**Yes No**

**Taking Part**

I have read the information sheet and I have been verbally informed about the above research and I understand what I am being asked to do.  Yes  No

I have been given the opportunity to ask questions about the project, and all questions have been satisfactory answered.  Yes  No

I agree to take part in the study which will include being interviewed and this will be audio recorded.  Yes  No

I understand that my taking part is voluntary; I can withdraw from the study at any time and I do not have to give any reasons for why I no longer want to take part, and that my withdrawal will not affect any aspect of my or my family's care.  Yes  No

If I do decide to withdraw I understand that the information I have given will not be used in the research.  Yes  No

**Use of the information I provide for this project only**

I understand that my personal details will be kept confidential and not be revealed to people outside the research team.  Yes  No

I understand that my words may be anonymously quoted in publications, reports, web pages, and other research outputs, but these will be anonymised at all times.  Yes  No

\_\_\_\_\_  
Name of participant [printed] Signature Date

\_\_\_\_\_  
Researcher [printed] Signature Date

For further information please contact:

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United Kingdom

[s.mcandrew@salford.ac.uk](mailto:s.mcandrew@salford.ac.uk)