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FEATURE ARTICLE

Hearing the voices of young people who self-harm: Implications for service providers

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ABSTRACT: *The incidence of adolescent self-harm and suicidal behaviour has increased globally, with many adolescents repeating the behaviour. While studies indicate that large numbers of adolescents who self-harm do not seek professional help, research focusing on barriers to help seeking from an adolescent perspective is limited. Locally, a rise in reported and unreported rates of self-harm and a number of suspected child suicides prompted the commissioning of a research project to ascertain young people's experiences of help and support for self-harm and how their future needs could be best met. Qualitative research, adopting an interpretive phenomenological analysis, was used to elicit narratives of adolescents engaging in self-harm. Data were collected via 1:1 interviews with seven participants and analysed in two stages: an analysis of each individual narrative, and thematic analysis across the group. Three themes were identified: (i) cutting out the stress; (ii) stepping onto the path of help; and (iii) cutting to the chase. In conclusion, mental health nurses have a vital role in providing knowledge and support to those likely to have initial contact with this vulnerable group and to the wider population, ensuring we more effectively address the increasing use of this risky behaviour among young people.*

KEY WORDS: *interpretive phenomenological analysis, qualitative research, self-harm, suicide, young people.*

INTRODUCTION

During the past decade, epidemiological studies have revealed a global increase in the incidence of adolescent self-harm and suicidal behaviour (McGorry *et al.* 2007; Patel *et al.* 2007; Scoliers *et al.* 2009). It is suggested that two-thirds of children and adolescents presenting with self-harm and suicidal behaviour are likely to experience depressive disorders, while those demonstrating suicidal intent are at increased risk of repeating the behaviour (Butler & Malone 2013; Green *et al.* 2011; Spirito *et al.* 2003). Recently, there has been a move to distinguish between non-suicidal self-injury (NSSI) and suicidal

behaviour, the former being proposed as a new diagnostic category in the Diagnostic and Statistical Manual-5 (American Psychiatric Association 2013). While NSSI is defined as the deliberate destruction of one's own body tissue with no suicidal intent, recognition continues to be given to the repetitive nature and the severity of the self-harm being associated with a high risk of considered or attempted suicide (Butler & Malone 2013; Zetterqvist *et al.* 2013).

Often studies examining issues of self-harm and suicide have explored underlying reasons for the behaviour and the implications for services (Dimmock *et al.* 2008; Dow 2004; Mental Health Foundation 2006). However, the increase in the rate of self-harm 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). While many studies have focused on those who attend emergency departments following

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acts of self-harm, community studies show that many adolescents who self-harm do not receive or seek medical attention (Hawton *et al.* 2002; Madge *et al.* 2011).

In the past 15 years, there has been growing commitment to listening to the views of children and young people 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 (United Nations 1989), with Article 12 stating the need to seek and take into account children's wishes when making decisions about their welfare. In the UK, the importance of involving children and young people in decisions regarding their health and social care needs have been reiterated in a variety of policies (Children and Young Person's Unit 2001; Department of Health 2002; National Service Framework for Children, Young People and Maternity Services, Department of Health 2004). In order to achieve the goals of such policies, emphasis has been given to actively seeking the views of children and young people with regards to planning, improving, and evaluating services, while the Children's Act (Department of Education and Skills 2005), calls for better integration of education, social care, and some health services.

With regards to mental health, studies undertaken to specifically explore the views of young service users have predominately related to child and adolescent mental health services (CAMHS) or more generalist services that address mental well-being. A limited number of studies has focused on service provision from a service user perspective, but many of these have been retrospective, presenting the views of adult service users, rather than the contemporaneous experiences of young people (Palmer *et al.* 2007; Tatiana *et al.* 2009). More specifically, with regards to services available to young people who self-harm, only two studies have reported on barriers to help seeking from an adolescent perspective (Fortune *et al.* 2008; Storey *et al.* 2005).

In 2011, a local Child Death Overview Panel in an urban area in the north-west region of England identified concerns relating to five suspected child/adolescent suicides and a rise in the rates of reported and unreported incidents of self-harm among this group of people (under 18 years of age) living in the area. After commissioning a needs assessment from the public health team and the CAMHS commissioner, the Child Death Overview Panel, together with the Safeguarding Children Board, commissioned a research project to ascertain the views of young people regarding their experiences of help and support for self-harm. The aim of the research was to elicit the narratives of young people who engage in self-harm and

suicidal behaviour, in order to identify what was helpful and/or unhelpful, and what their future needs might be from a diverse range of statutory and non-statutory services. It was anticipated that the findings from the project would help facilitate the development of a high-risk self-harm and suicide pathway for professionals working with this group of people. This paper reports on the findings of the research project.

REVIEWING THE LITERATURE

Literature relating to young people's perspectives of self-harm services is scarce. In searching the databases, only two articles were found that met the inclusion criteria (Fortune *et al.* 2008; Storey *et al.* 2005). On widening the search to include mental health and mental well-being services, a further six studies were identified; four focusing on mental health services (Buston 2002; Hart *et al.* 2005; Roose & John 2003; Worrall-Davis & Marino-Francis 2008), one on local health services (Curtis *et al.* 2004), and one on counselling services in schools (Fox & Butler 2007). For the purpose of this paper, we offer a synthesis of some of these papers to provide insight into the involvement of young people to date, followed by a synopsis of the two articles specific to exploring self-harm services from a young person's perspective.

Young peoples' involvement

Research has demonstrated that children as young as 4 years old are capable of reflecting on their experiences and are able to contribute to decision-making in complex and sophisticated ways (Clark & Moss 2001; Curtis *et al.* 2004; Roose & John 2003). A number of studies highlight how children and young people are often asked for their views, but not heard (Buston 2002; Fortune *et al.* 2008; Storey *et al.* 2005). McLaughlin (1999) concluded that while secondary school-aged pupils had a desire to be heard in school, what they experienced was feelings of not being listened to. Likewise, Le Surf and Lynch (1999) found that those in their upper teens and early 20s were not always listened to by adults and feared that confidentiality would not be honoured, and young males were particularly concerned about the social stigma attached to counselling. More recent studies report that many of these issues remain problematic for young people (Buston 2002; Fox & Butler 2007), and there has been no change in practice as a result of hearing children's and young people's views (Curtis *et al.* 2004; Fox & Butler, 2007; Worrall-Davis & Marino-Francis 2008). For many, if we are to meet the political agenda of involving young people in planning, improving, and evaluating services, it is

imperative that we act on recommendations made by young people (Fox & Butler 2007; Neil 2005; Worrall-Davis & Marino-Francis 2008).

Accessing help for self-harm

Two studies specifically focused on young people's behaviour regarding access to, and experiences of, self-harm services (Fortune *et al.* 2008; Storey *et al.* 2005). Storey *et al.* (2005) explored 74 young people's (16–22 years) accounts of support they had received for their repeated self-harming behaviour. Fortune *et al.* (2008), using a school-based survey exploring sources of help and barriers to help seeking before and after episodes of self-harm, collected data from 5293 15–16 year olds. Common findings from the studies centred on attitudes towards self-harm, resulting in young people having a negative self-concept, and professionals not listening to the young person (Fortune *et al.* 2008; Storey *et al.* 2005). For example, counsellors/clinicians were perceived as not understanding or not prepared to listen to the participants' perspectives, and the use of medication, with no accompanying interventions, was considered as 'fobbing off' (Storey *et al.* 2005). Also, friends were found to be the main source of support, with few adolescents seeking help from formal services (Fortune *et al.* 2008). Barriers to seeking help identified by participants included self-harm being perceived as a spontaneous act, and 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; being labelled as 'attention seekers'; not knowing whom to ask for help; and exposure to self-harm in their peer group and among their sex (Fortune *et al.* 2008). In light of their findings Fortune *et al.* (2008) called for more effective community-based prevention and school-based programmes to promote psychological well-being. Both studies highlight the importance of not only listening to children and young people regarding their experiences and views of how services can better address their mental health issues, but also the need to take action.

Methodology

Qualitative research, adopting interpretive phenomenological analysis (IPA), was used. While phenomenology acknowledges the complexities of human experience, recognizing the multiple realities constructed separately by each individual (Denzin & Lincoln 1998), IPA is particularly useful when wanting to explore the intersubjective nature of experience (Gale 2007; Lewis & Lindsey 2000). IPA is idiopathic, valuing the importance of each individ-

ual narrative, while recognizing the contribution each makes towards a larger account from a small group of people (15 or less) sharing their experience of the phenomena being studied (Reid *et al.* 2005). IPA requires the researcher to interpret each nuanced story, looking for similarities and differences across a group of participants (Brocki & Wearden 2006).

Ethical approval was granted from the university and from the National Research Ethics Service. All participants were guaranteed anonymity, and immediate and longer-term support were put in place should participants experience distress during or following the interview.

Data were collected from a purposive sample (Parahoo 1987). Narrative 1:1 interviews, lasting approximately 45–60 min, were undertaken with seven young people (13–17 years of age) who had experience of self-harm and/or suicidal behaviour, and who consented to participate in the study. All participants were white British females. Interviews took place at an agreed venue that felt comfortable for each of the participants and the researcher. Interviews were audio-recorded.

In keeping with narrative interviewing and IPA principles, the researchers independently read through each narrative line by line, analysing the recurrent themes within each individual story (Smith & Osborn 2008). The main themes from each narrative were subjected to a second analysis aimed at identifying which were common across the group. The researchers shared their analyses, and through this process, the final themes were agreed on. An independent researcher audited the initial descriptive, and later interpretative, analysis of the transcripts, assuring the authenticity and credibility of the findings.

FINDINGS

From the analysis, three major themes were identified: (i) cutting out the stress; (ii) stepping onto the path of help; and (iii) cutting to the chase: prioritizing self-harm on the public health agenda. In maintaining participant anonymity, all names used in the quotes are pseudonyms.

Theme 1: Cutting out the stress

Self-harming behaviour is multifaceted and often complex. There are a number of factors that predispose, trigger, and maintain the behaviour. Participants described triggers that comprise of significant life events and intrapersonal and interpersonal emotional turmoil, positive consequences that resulted in the behaviour being reinforced, and negative consequences that

compounded the young person's difficulties. A predisposing factor is described by Tina:

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

Tina believed herself to be an easy target for those who like to dominate. Triggers often related to interpersonal traumas, and these included the death of a significant other, being bullied, and the internalization (intra-personal) of negative experiences, resulting in stress:

When my nan died, that really triggered me, even though I was so young, I didn't understand. I was 13. That was the same year when I picked up the blade. (Nina)

It was just all at once: stress from school and stress from people, friends being horrible people, and the family arguing. (Lizzie)

Participants also discussed how friends' narratives impacted on their decision to self-harm, informing them of the benefits it brings:

She (friend) just said . . . it just relieved the stress. It relieves my stress, but it's not really a good thing. I mean the reason I done it was 'cos someone else was talking about it and saying how good it was. (Lizzie)

While life events might be difficult to cope with, self-harming appears to be an act of self-preservation:

It would be a relief from basically, like, everything that was going on; the stress. It was a kind of a relief for me because each cut that happened, was a relief from a problem. (Fiona)

It appears from the above that self-harming behaviour was maintained through its power to bring relief. However, the participants also talked about its negative effects and their shame in using the behaviour:

I felt ashamed. (Julie)

After the buzz had worn off, I felt terrible, guilty, bad. (Nina)

The 'shame' that the young people experienced was also demonstrated through their beliefs about how they were perceived by others:

I was thinking, what will he (general practitioner) think, if I was going to be judged, which put me off going. (Kim)

'Cos people say, we do it for attention or we want to kill ourselves or whatever, and we don't. That makes

people put off telling other people and getting help. (Julie)

What other people think about them and their behaviour is foregrounded in the data, but nonetheless, it did 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 young people don't go because they feel judged. (Kim)

For some of the young people, the attitude they perceived others to have, coupled with their original problems, led to suicidal ideation:

I've had suicidal thoughts, but I've never carried them out or nothing, but . . . I use (sic) to think of suicide quite a lot, because it was just so easy to end it all than just carry on. (Nina)

In the above accounts, it appears that shame, due to perceived stigma, might have inhibited these young people from seeking help.

Theme 2: Stepping onto the path of help

This theme provided insight into the various aspects of covert and overt services that are integral to education, health, and social care. Included in this theme were various dimensions of help that the young people considered important. These included making the decision to access help, who helped, helpful services, characteristics of helpers, and ending self-harm. For a number of the young people, finding the courage to ask for help was problematic:

I tried to. I built up the courage, but then when I got to it, it had diminished, the courage, and then I'd start panicking. (Kim)

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 (youth-offending leader). I did go into many meetings wanting to tell her and then ended up not saying anything. (Fiona)

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

I think without (the) YOS (youth offending service), I probably would have been lost, because I wouldn't have known where to go. (Fiona)

However, for some young people, access to help happened very quickly:

I didn't like it at all. I thought it was all too fast happening. I think they (parents) went into panic mode and sort of

'she needs help, we need to get as much as possible'.
(Kim)

In the main, the young people reported that they were referred to services via their general practitioner (GP), but 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:

The first connection with your GP is when 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 self-harming. (Fiona)

With regards to school-based services, it would appear that the young people accessed help through teachers in more prominent positions:

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. (Kim)

Once the self-harm was out in the open, all but one young person had access to multiple agencies, including school counselling and/or a dialectic behaviour therapy (DBT) group, CAMHS, and Camouflage:

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

Yeah, they (Camouflage) help me with things, like my scars. They were good. (Julie)

It would appear that once the young people 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:

If you know there's someone online that can listen . . . you only had to wait 10 minutes for there to be a real person; you're not waiting weeks for help. (Nina)

A range of people were mentioned by the young people as being helpful in terms of being there for them, being available to talk, and providing a sense of support:

My church pastor and my youth leader were great, always the kind of people who were here for you. (Fiona)

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)

A number of helping characteristics were identified as important, facilitating a positive experience of services. Helpful characteristics included being listened to; not being judged; confidentiality; trust; and being given an opportunity to talk to somebody independent of family, friends, or the school. Confidentiality and not being judged played a central role in relation to the young people feeling safe and having the confidence to discuss their problems:

They said to me, you do know that you can tell me anything in confidence. I think it was kind of the trigger that I needed to feel confident enough to tell her. (Fiona)

I don't like talking about it, but I like talking to her, because I know no one else will find out. (Julie)

For one participant, breaking confidentiality, but only after being consulted, made it easier for her to let her mother know about her self-harming:

They (teacher) asked me: 'Do you want me to ring your mum? I don't have to ring your Mum because it was confidential'. I thought I'd rather them ring my mum than me try and tell her. If school tell her, it may be easier, and it was. (Lizzie)

Likewise, those attending a DBT group also noted how they felt comfortable in the group because of not being judged and knowing they were not alone:

If there's people like you to speak to, they won't judge you, because they do a similar thing; they know how it feels. (Kim)

For some of the young people, it was also about understanding, professional expertise, and characteristics:

Because of his (CAMHS counsellor) attitude, it kind of made me realize 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)

The counsellors are very calm, and I think that calms you. They are very understanding. They don't try to jump to conclusions. They are caring as well. (Kim)

Only two of the young people made a comment directly related to negative experiences 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 what's triggered this? Was it home? Was it school problems? It was brushed off, because a lot of teenagers have home and school problems . . . it was like 'yeah, normal teenager, bye'. (Nina)

I never told them that I self-harmed. I did tell them that I was depressed and I'd had these suicidal thoughts, but she never said anything. She was like a nurse. If I had broken, a leg I'd go straight to her for a bandage or whatever, but she never said anything. (Julie)

One young person talked about strategies she found helpful:

Writing letters to people who have hurt you and then ripping them up. (Tina)

Some of the breathing helped, because it was very calming and took your mind off everything. (Tina)

Within the myriad of aspects that contributed to the young people's experience of being helped, pinpointing what they believed to be the reason for stopping the self-harm was important to identify:

A lot of people who do self-harm or who do feel suicidal need to know people are going to be there and not judge you. If I wasn't on the youth-offending order, personally I think I probably still would have been self-harming today. (Fiona)

I couldn't stop like that. I tried to wait. 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 2 hours, the whole bar. I felt great, like I was handling stopping. (Nina)

From the evidence presented, accessing help appears to be a complex and multifaceted process. With this in mind, the young people were asked for their thoughts regarding how self-harming behaviour could be better addressed.

Theme 3: Cutting to the chase: Prioritising self-harm on the public health agenda

The final theme focuses on what could be done in the future to help others who self-harm, and perhaps more importantly, to reduce the incidence of such behaviour. The theme encompasses knowing who can help, schooling in self-harm, and spreading the word. Part of the distress for young people appeared to be not knowing where to access help:

I did not have a clue in the slightest. I didn't know there was CAMHS. For me, it's basically just knowing that they are out there, whether you need them or not, it's always good to know. (Fiona)

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

They gave the numbers and emails, but it didn't say what they do. I didn't know if I should ring them or it's the wrong thing. (Lizzie)

Perhaps due to the age of the young people, all talked of their experiences related to self-harm within the context of school and schooling, and the part they played:

There are posters all around school (for smoking), but then there's nothing for counselling or anything like that. In my school, there are more people who actually self-harm than smoke or drink. Have an assembly about self-harming. (Lizzie)

I think there's (sic) only two (counsellors in school, and there's really quite a lot of people who do it, who need counselling. We need to get more helpers; it would make the difference. (Lizzie)

Beyond the bounds of school, the young people also emphasized the need to increase knowledge about self-harm to the wider population:

There should be more posters around. You see a lot of things on the television, alcoholics get a lot of help, like ring AA, but there's no help towards self-harm. (Nina)

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)

This section of the findings not only highlights the role of the school, but also draws attention to the fact that if the young people had known that help for self-harm was available, they might not have felt the need to initiate self-harming behaviour.

DISCUSSION

The findings from this study are congruent with other studies, reiterating the complexity of self-harm, particularly with regards to young people and their help-seeking behaviour (Buston 2002; Fortune *et al.* 2008; Storey *et al.* 2005). Within this and other studies, a number of factors that predispose, trigger, and maintain self-harming behaviour have been identified. These include bullying; significant life events, such as someone close to the young person dying; and family and/or school problems (Fox & Butler 2007; Roose & John 2003). In addition, findings from this study also implicate friends in the decision-making to use self-harm as a coping strategy. While self-harm as a coping strategy is widely acknowledged within more progressive mental health services (Butler & Malone 2013; Fortune *et al.* 2008; McAllister 2003;

Storey *et al.* 2005), the immediate relief, particularly the power of cutting and its ability to reduce internal distress, should not be underestimated. For those professionals less familiar with the psychological complexities of self-harm, realizing its potential 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 routinely accessible to young people (Butler & Malone 2013).

Regardless of any positive effects of self-harm, shame eventually became associated with the behaviour (Fortune *et al.* 2008; Fox & Butler 2007; Le Surf & Lynch 1999). Despite this being a concern for young people, it also appeared to perpetuate their negative feelings about self, creating further anxiety and the need to punish self (Holden & Delisle 2006; Scoliers *et al.* 2009; Skogman & Öjehagen 2003). The perceived stigma complicates the help-seeking process, making young people afraid to talk about their problems (Fortune *et al.* 2008; Fox & Butler 2007). Not being able to talk about problems might in turn exacerbate feelings of being alone; a situation having the potential to lead to suicidal ideation.

A number of studies have highlighted the dilemmas young people have about sharing their problems with other members of their families (Fortune *et al.* 2008; Roose & John 2003). Such concerns include issues of being open in front of parents, a sense of protectiveness, worries regarding parental reactions, and causing hurt to those they care about (Day *et al.* 2006; Fortune *et al.* 2008; Hart *et al.* 2005; Street *et al.* 2005; Street & Svanberg 2003). All these issues were discussed in this study. Some of the girls did not want to worry their mothers, while others identified existing family problems, which they did not want to add to. However, difficulties arose in knowing who to turn to, and more importantly, who they can trust in terms of confidentiality. Consistent with a number of other studies (Fox & Butler 2007; Howieson & Semple 2000; Le Surf & Lynch 1999; Pope 2002; Roose & John 2003), trust and confidentiality appeared to play a central role for the young people in disclosing their self-harm. The importance of trust and confidentiality in terms of developing therapeutic relationships with young people is well documented (Fortune *et al.* 2008; Wright & Jones 2012). Regardless of being told that certain things would have to be reported to other agencies, the young people in this study felt reassured that disclosure of self-harm would be kept confidential, and knowing this at times facilitated finding the courage to discuss their experiences.

The difficulties regarding who to tell cannot be ignored, and thought needs to be given to providing

sensitive confidential help to young people, while at the same time considering support that their parents/families might require. While it has been argued that parents/guardians are best placed to spot early signs of distress and/or self-harm, they often struggle to understand and cope with self-harm (Oldershaw *et al.* 2008).

In the present study, a lack of confidence and courage impeded some of the young people accessing help. However, the participants suggested that once they were engaged in regular meetings with an adult confidant, they eventually found the courage to reveal their self-harming behaviour. This could be problematic, because for it to occur, it is implicit that behaviour warranting input has already started, whereas it might be more productive to ensure help is available before the onset of self-harm.

For some of the young people, it was teachers who initiated discussion, either directly about self-harm or indirectly about their emotional well-being. While it has been suggested teachers are not appropriate to take on the role of counsellor (British Association of Counselling and Psychotherapy 2001; Roose & John 2003; Fox & Butler 2007), the role they played for many of the young people in the present study was pivotal in the young people accessing appropriate services. Once they became involved with services, they began to talk to a range of people from a variety of disciplines. A number of helping characteristics were identified as important, and the presence of such characteristics facilitated a positive experience of services (Hart *et al.* 2005; Storey *et al.* 2005). Helpful characteristics were identified by participants as being listened to; not being judged; confidentiality; trust; being given an opportunity to talk to somebody independent of family, friends, or the school; understanding; and professional expertise.

All but one of the young people indicated that face-to-face support was their preferred option for receiving help (Roose & John 2003). Given the preponderance of social media, the authors were surprised by this, but the younger participants believed it was important to know who you are talking to. Counsellors from Kooth, a local organization providing face-to-face, one-to-one counselling, DBT skills groups within various schools, and counselling and support via the Internet, were the main providers of face-to-face support. However, some of the young people felt more counselling support was needed in schools, a proposition supported by others (Baruch 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 others engaging in self-harm as a way of dealing with difficulties. Being

involved with various services, and the attunement of those delivering them, facilitated the end of the behaviour, but this is an area for further exploration to promote the prevention of self-harm.

School is well placed to address the emotional needs of the age group when the onset of self-harm is most likely to occur. The young people talked of their experiences related to self-harm within the context of school and the part it played. While we are not advocating 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 research, an independent counselling service, readily available to all children and young people in the educational system, would be of great benefit (Cooper 2004; Department of Health 2004; Fortune *et al.* 2008; Fox & Butler 2007; Pope 2002; Roose & John 2003). All the young people in the present study wanted more knowledge about self-harm via informative assemblies and posters being placed around school that are integral to other public health alerts, such as smoking and drinking. Beyond the bounds of school, there was emphasis on the need to increase knowledge about self-harm to the wider population, in the hope of making serious inroads into this risky behaviour that more of our children and young people are turning to.

LIMITATIONS OF THE STUDY

A limitation of the present study is that all of the participants are female. With regards to self-harm, boys are often referred to as a hidden population, and this is mirrored in this study. Recruiting to the study was difficult, and this might have been due to the sensitive nature of the topic and/or the shame that appears to be integral to self-harm. 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 as being more problematic for boys, and could have impacted on the recruitment of males to this study.

CONCLUSION

This research project was part of a local multiphase workforce development project. In an earlier section of this paper, 'Involving young people', having listened to the young people who self-harm, it is important that their voices are heard and appropriate changes in practice are made. In implementing the actions suggested by the young people, mental health nurses would have a pivotal role in sharing expertise in terms of addressing self-harm

in educational, primary health, and social care settings. Raising awareness in schools, communities, and families will highlight self-harm as a serious health topic, give insight and understanding into the behaviour, and provide knowledge of available help. Educating and supporting those professionals most likely to come into contact with young people who engage in self-harm might facilitate earlier detection of problems that are commonly associated with the behaviour. At the wider social level, mental health nurses are best placed to engage in the debate as to where to place age-appropriate counselling services, to instigate the development of support networks for young people and their parents/guardians, to undertake further research specifically aimed at males who self-harm, and to explore the role of social media in relation to self-harm within this age group. While the number of participants is limited, they do form part of the local community and gives a depth of knowledge that has the potential to contribute to the effective delivery of the local emotional well-being strategy.

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