Self-harm in East London adolescents

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PhD Thesis

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Abstract

The prevalence of adolescent self-harm is higher in the community compared with self-harm monitored through service use, as only a minority of young people seek help. There has been limited longitudinal community-based research on adolescent self-harm, particularly in ethnic minorities. This research aimed to explore self-harm in an ethnically diverse sample of adolescents, with particular focus on social and psychological factors.

Two studies were conducted with a sample of East London adolescents to examine the prevalence, risk and protective factors for self-harm, and to explore how young people talk about self-harm. The first involved analysis of longitudinal data from Phases 2 and 3 of RELACHS, a school-based study on adolescent health. In Phase 3, 1023 participants aged15-16 completed self-report surveys. The second, qualitative study explored self-harm in the context of East London adolescent life. Thirty interviews were conducted with 15-16 year olds, 20 of whom had self-harmed.

The 12 month prevalence of self-harm was 10.6% for girls and 3.4% for boys (7.3% in total). Regression analysis showed self-harm was strongly associated with current and previous depressive symptoms, conduct problems, low support from family, low parental warmth and high maternal strictness. Relationships with borderline psychological distress indicate that self-harm is not limited to those with serious mental health problems.

The qualitative study showed that definitions and experiences of self-harm varied. It was viewed as difficult to comprehend by those who had never done it, and also some who had. Many participants were hesitant to identify themselves as having self-harmed and explained reluctance to disclose self-harm to others. The qualitative study showed no evidence that self-harm was more acceptable in any ethnic group. However, for some, family and cultural restrictions exacerbated other stressors.

The results of these two studies complement each other, providing further insight into self-harm in East London adolescents. Findings could inform the development of an intervention about self-harm and emotional well being for adolescents.

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"You do it to yourself, you do
And that's what really hurts
Is that you do it to yourself
Just you and no-one else" (Yorke 1995)

1.1. Personal introduction

There are many allusions to self-harm in today's society, with and without reference to suicidal ideation. Self-harm is a phenomenon which is considered confusing, yet it is mentioned in many forms in mainstream society such as in song lyrics, news reports, websites, artworks, novels, plays, films, even recruitment advertising. There is some concern reported in the media over increasing publicity about self-harm and ideation being glamorised in music culture. For example, "emo" band My Chemical Romance have come under attack with their song "Welcome to the Black Parade" (Clench 2008). However, self-harm is not a recent phenomenon, nor are references to self-harm. In Romeo and Juliet, Shakespeare depicted Juliet taking poison, initially harming herself without intending to die, and then later harming herself with clear suicidal intentions (Shakespeare 1988).

Reflecting on my own interest in the topic, I first heard of self-harm during secondary school. A friend had taken an overdose, and later tried cutting his wrists with a butter knife after he woke up in hospital. At the time I thought it was sad, but didn't relate to it, understand what he'd done, or why. I simply hoped he'd feel better soon. Later, studying psychology, I met a few more people with scars on their arms. I recall wondering about it, but never actually spoke to any of them about it.

More recently, doing voluntary counselling and emotional support work reminded me about the issue of self-harm once again. I seemed to be hearing about it more frequently, and I still didn't really get it. Why would someone hurt themselves like that? Were they suicidal? If not, what was going on? In the role of providing support over the phone, it was appropriate to explore feelings, but not other aspects of self-harm that I had begun to wonder about. From telephone counselling, I progressed to face-to face emotional support at music festivals. These events were attended by a high proportion of young people, and at some events there were many scars on display, and people of all ages talking about self-harm.

As my insight grew, so did my curiosity, and it was at that point I was considering undertaking a PhD – and it seemed like an interesting topic to explore. Initial background reading about self-harm informed me a great deal, and also illustrated that there were many aspects of this behaviour which were not well understood. Identification of an area with scope for further research, along with support and encouragement from my supervisors led to a funding proposal, weaving this topic in with the study I had been working on… so began my PhD journey.

While undertaking this research, the mention of my topic has elicited innumerable personal stories of self-harm. These have been from people I have spoken with as a part of the research process and in general conversations. Since beginning my PhD, I have also been asked many times to try to explain or demystify self-harm by other people who have heard or read about it, but "just didn't really get it". The interest in this topic from other people has been a key motivation for me – it is something that is known, yet not well understood.

To me, the findings from my studies, and the personal stories I have heard along the way justify the need for current and future research, with the aim of understanding this complex, often secretive and lonely behaviour.

1.2. Study introduction

Suicide and suicidal behaviour have become an important public health issue over recent decades, placing great demands on health services (Department of Health 2002;Mental Health Foundation 2006). This has been shown in national statistics (Brock et al. 2006) and also in monitoring presentations of suicidal behaviour to hospital (Hawton et al. 1996;Hawton et al. 2003a;Hawton et al. 2000). It has been estimated that there are 25,000 young people who present with self-harm to hospitals in England and Wales each year (Hawton et al. 2000). Studies in the UK have reported increased rates of presentation to hospital for deliberate self-harm, and also an increase in repetition rates (Hawton et al. 2003a;Hawton et al. 2000). As a key predictor of later suicidal behaviour (Brent 1995;Cooper et al. 2005;Fergusson et al. 2005;Pearce & Martin 1994), and a public health issue itself, self-harm in young people is an important topic that requires better preventive knowledge and therefore research.

Self-harm is an alarmingly prevalent behaviour among young people as shown repeatedly by school-based research in different populations (Baldry & Winkel 2003;Borowsky et al. 2001;DeLeo & Heller 2004;Garrison et al. 1991;Hawton et al. 2002;Hawton et al. 2006;Madge et al. 2008;Martin et al. 2005;Patton et al. 1997;Ross & Heath 2002;Steinhausen et al. 2006;Steinhausen & Winkler Metzke 2004;Stewart et al. 2006;Wichstrom 2000;Ystgaard et al. 2003). Self-harm has been emphasised as an important issue within the National Suicide Prevention Strategy for England (Department of Health 2002). The National Inquiry into Self-harm in Young People recently compiled evidence from personal accounts, expert opinions and research in the area. This report highlighted that self-harm is a pervasive issue for young people, often used as a coping strategy. If self-harm were to be disclosed, both the initial response from others, and help provided need to address the underlying issues leading to self-harm, rather than focusing on the acts of harm themselves (Mental Health Foundation 2006).

There is evidence self-harm has a high prevalence in young South Asian women in the United Kingdom (Bhugra et al. 1999b;Cooper et al. 2006;Crawford et al. 2005;Merrill & Owens 1986). There is not clear evidence about whether this is mirrored by variation in self-harm in adolescents from minority ethnic groups, and thus there is scope for further research, particularly in population samples. There has been limited research on self-harm in population samples of adolescents from minority ethnic groups in the UK (Hawton et al. 2002;Meltzer et al. 2001), as most research on ethnicity and adolescent self-harm involves young people who presented to services (Bhugra et al. 2003;Bhugra et al. 2004;Handy et al. 1991;McGibben et al. 1992;Merrill & Owens 1986). As only a minority of adolescents who self-harm seek help (Hawton et al. 2002), conducting research with population samples has scope to increase understanding and inform future interventions to promote better emotional health in young people, and to potentially reduce suicidal behaviour.

This thesis includes a comprehensive literature review on self injurious behaviour in adolescents. The research conducted for this thesis has taken a mixed methods approach, firstly aiming to identify associations with self-harm through analysis of quantitative data from the Research with East London Adolescents Community Health Survey (RELACHS). This longitudinal school-based study included adolescents from a range of different ethnic backgrounds. A subsequent qualitative study explored how young people view and talk about self-harm in more depth. The two studies undertaken are introduced in more detail in Chapter 3. Figure 1 presents an overview of the contents of this thesis. Working with a young, culturally and racially diverse sample in the UK make this research unique, with

scope to make a valuable contribution to the field of self-harm research and also to inform future public health interventions.

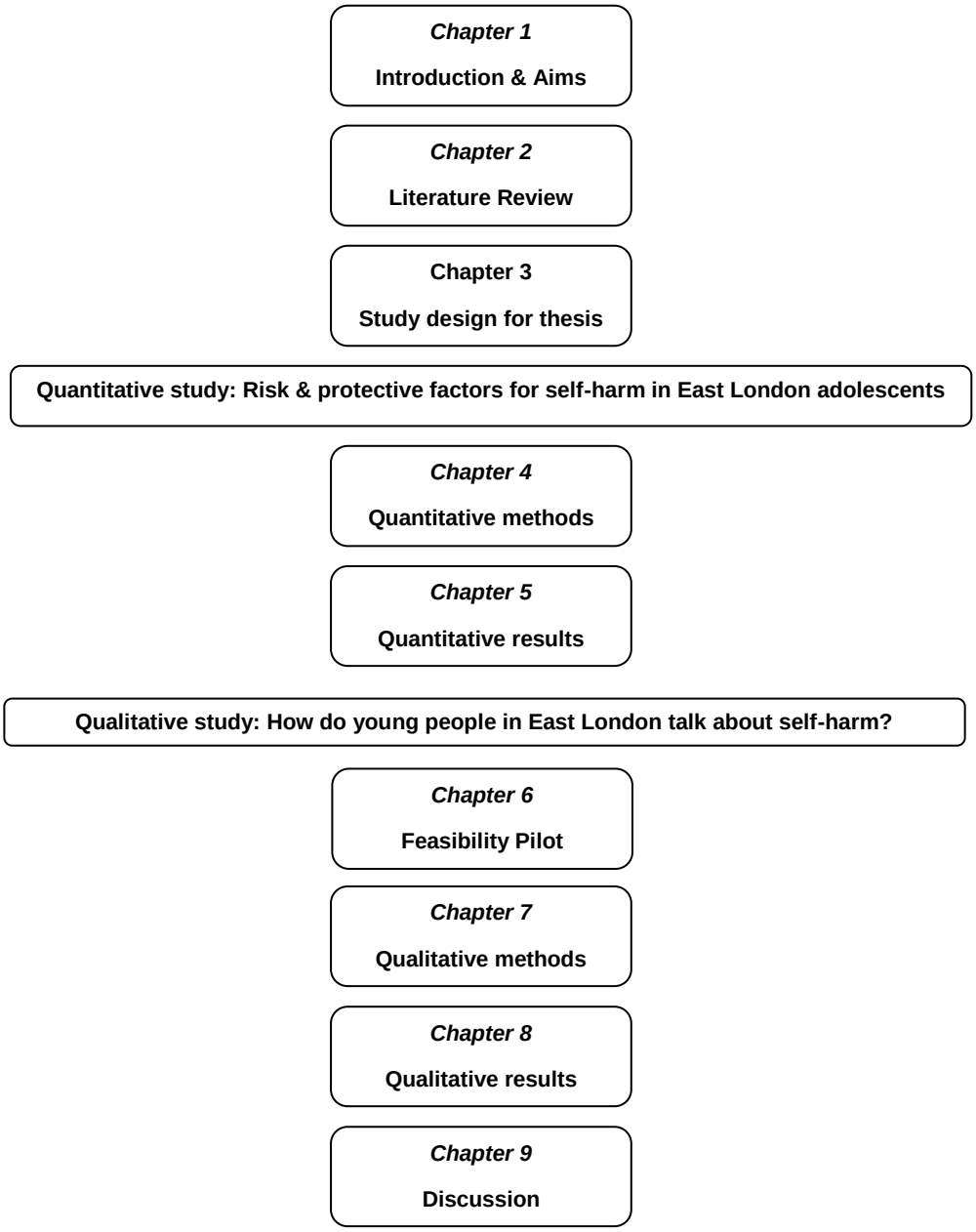

Figure 1: Thesis outline and chapter structure

1.2.1. Work undertaken by the doctoral student for this thesis

The doctoral student began work on this thesis having been based in the Centre for Psychiatry, Barts and the London School of Medicine & Dentistry for four years, having worked on the RELACHS study for three years. She drafted the proposal for this mixed methods study which was developed and submitted for funding by her supervisors.

As an employee on the RELACHS study, the doctoral student had attended steering committee meetings for the study, assisted with organisation of data collection, data entry, data cleaning and recruitment of the data collection team for Phase 2 of RELACHS. In order to make an individual contribution for this thesis, the student undertook a comprehensive review of the literature on self-harm in adolescents, particularly relating to population studies and research with minority ethnic groups. She researched and identified appropriate assessments of self-harm to include in Phase 3 of RELACHS, with consent from the RELACHS steering committee, contributing to Phase 3 questionnaire design. She once again contributed to the organisation and procedure of data collection, entry and cleaning as part of the data collection team. The quantitative analysis conducted for this thesis was conducted by the doctoral student.

The qualitative pilot and main qualitative study in this thesis were designed and conducted by the doctoral student with the assistance of her supervisors. The qualitative study and pilot both required independent ethical approval, which was obtained by the doctoral student and her supervisors.

1.3. Aims

The aims of this thesis are:

1) To review the literature and summarise current knowledge on adolescent self-harm, with emphasis on community-based research with minority ethnic groups.

2) To identify the prevalence of self-harm in an ethnically diverse, community-based adolescent sample in East London to compare with other studies.

3) To investigate prospective and cross-sectional associations between potential risk factors for self-harm in a sample of East London adolescents.

4) To explore the subjective experience of self-harm and attitudes to help-seeking, in order to gain some understanding of this behaviour as perceived by young people within the context of being an East London adolescent.

In addressing these aims, this thesis will draw on influences from research in a range of fields, which involve different theoretical approaches and methods. Broadly, this research will address psychological and social factors relating to self-harm in young people. These are approached using an epidemiological risk factor model (Bhopal 2002) in the first study, which informed the development of the second, qualitative study. This was undertaken within a social science model influenced by psychology and sociology (Pope & Mays 1995;Snape & Spencer 2003). These different approaches provide complementary insights into self-harm at a population level, and also at an individual level. As these studies were based within a context of ethnic diversity in East London, research on culture, ethnicity and transcultural psychiatry has also been influential when developing and conducting this research (Bhugra 2004).

2. Literature Review

2.1. Introduction

The literature review will appraise current research and theoretical models of self-injurious behaviour. It will define and explore self-harm and associated psychosocial issues in young people. The emphasis will be on self-harm studied in populations or community-based longitudinal and cross-sectional studies, addressing the first aim of the thesis stated in Chapter 1.

This section will introduce the literature review, and define terms used in the discussion of research on self-harm. Section 2.1.1. presents a description of the approach taken within this literature review, including a commentary the types of studies included in this review. Sections 2.2-2.7. contain a general introduction and background for self-harm research. It will outline the definitions used, characteristics of self-harm and prevalence reported in previous research. This includes previous research on repetition of self-harm, followed by views on disclosure, help-seeking and theoretical models of self-harm. Social and psychological factors relevant to the empirical research in this thesis will then be discussed in Sections 2.8-2.10. Social factors include ethnicity, culture, socio-economic status, social support, interpersonal relationships and exposure to self-harm. The psychological factors refer to individual mental health and illness, including discussion of depression, anger, anti-social behaviour and anxiety.

The literature review in Chapter 2 provides a background for the studies within this thesis, and the literature in this review will be used throughout the document. Research relating to the design of the two studies conducted will be discussed in Chapter 3. Specific research informing aims and objectives will be noted with the methodology for the two studies; in Chapter 4 for the quantitative study and Chapter 7 for the qualitative study. Findings from this doctoral research will be discussed in the context the wider literature in Chapter 9.

Definitions of terms used throughout this thesis

The emphasis within this thesis is on *self-harm.* As many studies combined self-harm with *attempted suicide*, both of those terms will be used throughout this thesis, as discussed in section 2.2. In discussion of cross-sectional research, the findings will be referred to as

associations, rather than *risk* or *protective* factors. In this context, risk implies probabilities of negative outcomes (Schoon 2006), including behaviours such as self-harm or attempted suicide.

This thesis refers to *population* and *community* studies. Broadly, *population* refers to the group of people being studied (Bhopal 2002), such as adolescents in East London. *Community* studies refer to those where the sample is based on people attending certain schools, or living in a certain area. These two terms are used in contrast to *service-based* studies, which, in this thesis, refer to people who have presented to hospital, or used medical services prior to being recruited into a study on self-harm.

Definition of adolescence

As this thesis focuses on self-harm in adolescents, a definition of *adolescence* is required. It is generally agreed that adolescence begins after puberty, however, developmental psychologists acknowledge the difficulty in pinpointing the start and end of adolescence as the physical, psychological and social transitions involve ambiguity as roles and relationships change (Coleman 1995). In this thesis adolescence will refer to ages 12-17 years, as the data will address young people within this age range. This is a truncated range for adolescence, and the issues highlighted in this work may be relevant to slightly older people as well.

2.1.1. Approach to literature review

This section presents an overview of the sources used in this literature review. There is a large body of literature on self-harm and attempted suicide, yet relatively few studies which specifically address the core issues of this thesis; self-harm in adolescents from minority ethnic groups in the UK, particularly those who have had little or no contact with medical or psychological services.

The review included a comprehensive search of published literature. Initial searches were conducted using Medline, Psychinfo and Embase databases. Key terms included variations of “self-harm”, “self-injury”, “attempted suicide”, along with “adolescent”, “teen” and “young people” to identify relevant articles. The search strategy was developed following consultation with a librarian, identifying suitable “mesh terms” to use and

methodology to check citations as well as following-up references within the papers identified.

Consideration was given to the location of studies to be included in the review, given that the research for this thesis was to be based in East London. Ideally this would have been a review of longitudinal research in the UK looking at predictors of self-harm in adolescents. However, there was only one study meeting this criteria at the time of the review, and that study reported findings from 19 year old participants in Scotland (Young et al. 2006). Thus, it was necessary to broaden the scope of the review. Key sources are noted below.

Longitudinal studies

Evidence in this literature review has been taken from a range of community-based longitudinal studies, particularly addressing 15-16 year olds (Borowsky et al. 2001;Fergusson et al. 2000;Fergusson et al. 2003;Haavisto et al. 2005;Lewinsohn et al. 1996;Martin et al. 2005;McKeown et al. 1998;Reinherz et al. 1995;Sourander et al. 2001;Sourander et al. 2006;Wichstrom 2000;Young et al. 2006). Longitudinal studies provide the strongest evidence as they have scope to analyse prospective relationships between psychosocial factors and self-harm, as well as providing prevalence estimates. Due to limited longitudinal research having been conducted in the UK, studies conducted outside the UK which addressed adolescent self-harm or attempted suicide at a community level were also included. The locations of studies have been noted within the review.

Cross-sectional studies

Papers reporting on data on adolescent self-harm from one time point have also provided key information for this review. Key references relate to research in secondary schools in England (Evans et al. 2005;Hawton et al. 2002;Rodham et al. 2004). Additional publications relating to the CASE (Child and Adolescent Self-harm in Europe) study have also been considered key references, as questions on self-harm were adapted from that study for this thesis (DeLeo & Heller 2004;Hawton et al. 2006;Madge et al. 2008;Scoliers et al. 2008;Ystgaard et al. 2003). Other key cross-sectional analyses used in this thesis include studies conducted in a range of countries (Garrison et al. 1993;Hallfors et al. 2004;Meltzer et al. 2001;Muehlenkamp & Gutierrez 2004;O'Sullivan & Fitzgerald 1998;Patton et al. 1997;Rey Gex et al. 1998;Roberts et al. 1997;Rosenberg et al. 2005;Ross & Heath 2002;Stewart et al. 2006). This list includes cross-sectional studies

specifically designed to examine self-harm in secondary schools (Hawton et al. 2002;Madge et al. 2008), cross-sectional analysis within longitudinal studies (Hallfors et al. 2004;Patton et al. 1997) and analysis of national survey data (Meltzer et al. 2001). Such studies provide evidence about prevalence and associations with self-harm.

Research on minority ethnic groups

The literature on self-harm in minority ethnic groups in the UK was limited in community studies. There was some commentary in population-based studies in the UK listed above (Hawton et al. 2002;Meltzer et al. 2001), however, ethnic differences within UK samples tended not to be the focus of population-based papers. Although there is interest in researching minority ethnic groups, very large numbers would be required for analysis, and thus it is a difficult topic to research in population-based research.

For the purposes of this review, relevant studies specifically addressing self-harm in minority ethnic groups involving samples recruited after presentation at accident and emergency (A&E) or admission to hospital following an episode of self-harm have been included (Bhugra et al. 2003;Bhugra 2004;Bhugra et al. 2004;Goddard et al. 1996). This was done with the acknowledgement that service-users are a sub-set of people who self-harm, as they have sought help. In the absence of relevant work with young people, publications from the UK addressing self-harm in South Asian adults were also considered for this review (Bhugra et al. 1999b;Bhugra et al. 1999a;Bhugra et al. 1999c;Bhugra & Desai 2002;Biswas 1990;Cooper et al. 2006;Merrill & Owens 1986). Although this broadened the scope of the review, it was deemed necessary to provide background information for the development of studies conducted for this doctoral thesis.

Qualitative studies

In addition to literature based on quantitative methods, qualitative studies were also considered within this review. As the body of qualitative research on adolescent self-harm was limited at the time of this review, inclusion criteria were extended to relevant studies with adults and samples recruited through use of services. This research provides more depth in understanding about how self-harm is viewed by different groups, and providing insights into the mechanisms behind self-harm and illness behaviour (Anderson et al. 2003;Biddle et al. 2007;Coggan et al. 1997;Redley 2003;Ross & Heath 2002;Sinclair & Green 2005).

Reviews and additional sources

In addition to journal articles on empirical research in these areas, reviews have been considered, (Beautrais 2000;Bhui et al. 2007;Brent 1995;Evans et al. 2004), along with papers and texts presenting theoretical approaches to self-harm (Bell 2000;Pattison & Kahan 1983;Williams 1997). Other relevant sources have been included, such as guidelines relating to self-harm (National Institute for Clinical Excellence 2004;Samaritans 2002). Some evidence has been noted from the Mental Health Foundation's National Inquiry. This was done with the understanding that it was a very broad piece of work and that although inclusive, the findings may not have the validity or reliability of peer reviewed publications (Mental Health Foundation 2006).

The general introduction to self-harm definitions and methods of harm draws on international research with people of all ages to provide the background for this piece of research.

2.2. Definitions of self-harm

People harm themselves in a variety of ways and for a variety of reasons. Debate about the definition of self-harm is an ongoing issue (Borges et al. 1995;Silverman 2006). There are two types of intentions incorporated in self-harm; the intention to initiate the behaviour, and the intended outcome (Kreitman 1977). The intention to initiate the behaviour is often assumed, and self-harm is referred to as "*intentional*" (World Health Organisation 2006) or "*deliberate*" (Hawton et al. 2002). However, it may be difficult to pinpoint the intention to act. Conscious motivation is not always evident in reports of self-harm, and may remain obscure if the individual is unable to give a lucid account of his or her actions at the time (Kreitman 1977). 'Retrospective contamination', is when the outcome of the actions may influence the account given after the event. This could further cloud the assessment of self injurious behaviour or suicide attempts (Kienhorst et al. 1995). With respect to the intended outcome, if a person injures him or herself, is it possible to ascertain what they were really intending to do?

Self-harm and attempted suicide are difficult to define both theoretically and in practice (Fairbairn 1995a;Silverman 2006). If self-harm involved suicidal ideation, it could be interpreted as an attempted suicide. Suicidal ideation in this context refers to any thoughts

or cognitions about suicide, ranging from fleeting ideas through to specific concrete plans to end one's life (Bridge et al. 2006;Lewinsohn et al. 1996).

Some argue that if a person intends to end his or her life and does so, it is usually referred to as suicide, however, if they do not die, their actions may be referred to as *attempted suicide* irrespective of their true intentions (Fairbairn 1995b). This implies that a person may intend only to injure themselves, and if they did not cause their own death, this would be misclassified as *attempted suicide*. In many cases, the outcome of living or dying may not be a reliable indicator of the intentions of the individual (Fairbairn 1995b). Similarly, the choice of methods of self-harm, or precautions taken to prevent discovery may also not be reliable indicators of the suicidal intent (Shaffer & Gutstein 2002). Individuals may have different ideas about what constitutes suicidal behaviour (De Wilde & Kienhorst 1994); for example, lack of knowledge about the impact of their behaviour could alter both the behaviour and the interpretation of the behaviour afterwards (Fairbairn 1995b). If an individual was unaware of the amount of a certain substance required to cause death, the effects of that substance could be unrelated to its intended use. This is particularly pertinent amongst adolescents (Shaffer & Gutstein 2002). Similarly, events could be staged to appear accidental, disguising a true attempt to end one's own life.

Different definitions are pervasive in the literature. These include studies where "*deliberate self-harm"* includes harm with, or irrespective of suicidal ideation (Bille-Brahe et al. 1994). Other studies place ideation, acts of self-harm and suicide attempts on a continuum ranging in severity (Harkavy Friedman et al. 1987;Pearce & Martin 1994;Sourander et al. 2001), however this definition could preclude the notion of self injurious behaviour which is not suicidal; a concept generally accepted in current literature (DeLeo & Heller 2004;Fairbairn 1995a;Fairbairn 1995b;Kerkhof 2000;McKeown et al. 1998;Nock et al. 2006;Ross & Heath 2002). Pattison and Kahan (1983) proposed a "Deliberate Self-harm Syndrome" where an individual would impulsively and repetitively inflict non-lethal injuries on him or her self with the aim of releasing anger and anxiety. Many acts may occur in response to emotional turmoil (Kerkhof 2000) and function as an expression of distress (Rodham et al. 2004) or a cry of pain, than an attempt to end one's life (Williams 1997).

Multiple motivations for self-harm may imply ambiguity in the actions, however, acknowledgement of intentions can distinguish purposeful from accidental actions (Andriessen 2006). Suicidal ideators and those who purposely harm themselves without suicidal thoughts may have different concerns (Haavisto et al. 2005), and thus, trying to

disentangle these terms is difficult, yet important for the exploration of self injurious behaviour.

The use of different terminology further complicates attempts to compare research from different countries (Rey Gex et al. 1998). The North American literature tends to favour *"attempted suicide"* and the European literature more often refers to *"deliberate self-harm"* (Bille-Brahe et al. 1994;Evans et al. 2004). Other terms used in the literature include *"parasuicide"* (Kreitman 1977), *"NSSI: non-suicidal self-injury"*, (Nock et al. 2006), *"non-fatal non-suicidal physically self damaging act"* (McKeown et al. 1998), *"suicidal gestures"* (Bhugra et al. 1999a;Bhugra et al. 1999c) with actions implying communication to others, rather than intentions to kill oneself (Lewinsohn et al. 1996;Shaffer & Gutstein 2002), as well as *"self mutilation"* (Ross & Heath 2002), *"suicidal behaviours"* (Fergusson et al. 2000;Horesh et al. 2003), and *"suicidal acts"* (Miller & Taylor 2005). Studies on methods of self-harm often refer to people who have hurt themselves by the harm they have done, for example, referring to the act itself; *"self-injury"* as opposed to *"self poisoning"* (Horrocks et al. 2003), or distinguishing *"self-cutters"* from *"self-poisoners"* without assignation of suicidal ideation (Patton et al. 1997;Rodham et al. 2004). Recent studies make a point of referring to *"self-harm"* rather than *"deliberate self-harm"* which was more common in earlier literature, (Cooper et al. 2006) as patients reportedly prefer the term "*deliberate"* not to be used (Skegg 2005).

"Intentional self-injury" has been incorporated and classified by method of harm in the International Classification of Disease (ICD-10), (World Health Organisation 2006). Specifically defined behaviours are listed in categories X60-X84 by method of injury (see Table 1). Other external causes of morbidity and mortality with undetermined intent are categorised in sections Y10-Y34. These classifications include behaviours of self-inflicted injury or poisoning, and also attempted suicide.

Table 1: Classification of self-harm from the ICD-10

Classification	Description of type of harm
X60	Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
X61	Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified
X62	Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
X63	Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system
X64	Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
X65	Intentional self-poisoning by and exposure to alcohol
X66	Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours
X67	Intentional self-poisoning by and exposure to other gases and vapours
X68	Intentional self-poisoning by and exposure to pesticides
X69	Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances
X70	Intentional self-harm by hanging, strangulation and suffocation
X71	Intentional self-harm by drowning and submersion
X72	Intentional self-harm by handgun discharge
X73	Intentional self-harm by rifle, shotgun and larger firearm discharge
X74	Intentional self-harm by other and unspecified firearm discharge
X75	Intentional self-harm by explosive material
X76	Intentional self-harm by smoke, fire and flames
X77	Intentional self-harm by steam, hot vapours and hot objects
X78	Intentional self-harm by sharp object
X79	Intentional self-harm by blunt object
X80	Intentional self-harm by jumping from a high place
X81	Intentional self-harm by jumping or lying before moving object
X82	Intentional self-harm by crashing of motor vehicle
X83	Intentional self-harm by other specified means
X84	Intentional self-harm by unspecified means

Source: (World Health Organisation 2006)

Researchers who conducted World Health Organisation (WHO)/EURO multi-centre study on parasuicide, reporting on adult presentation to European hospitals (Bille-Brahe et al. 1994;Platt et al. 1992) adopted the following definition of parasuicide:

"An act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realizing changes within the subject desired via the actual or expected physical consequences" (Platt et al. 1992).

In that study, four possible interpretations of the relationship between parasuicide and attempted suicide were explored, highlighting issues for clarification and specificity of research in this area: (i) Is parasuicide a sub-category of attempted suicide? (ii) Is attempted suicide a sub-category of parasuicide? (iii) Are parasuicide and attempted suicide mutually exclusive, dependent on degree of suicidal intent? (iv) Should the terms be used interchangeably, as intention is difficult to ascertain (Bille-Brahe et al. 1994)? These questions could apply to the term 'self-harm', and will be discussed in turn.

Considering the first question, not all self-injury involves suicidal ideation, and thus it is inappropriate to consider all self-injury as a type of attempted suicide. Some self-injury may involve suicidal ideation and, thus it could be considered that attempted suicide is a sub-category of self-harm. However, delineation of that sub-category would be difficult as ideation is challenging to ascertain after the event. The third possibility relates to the assessment of suicidal ideation, and how it could be used as a criterion to differentiate parasuicide from attempted suicide. It is feasible that self-harm and attempted suicide both include a range in severity relating to suicidal ideation, and there is no reason to assume that they are mutually exclusive.

The final proposition is that intent is sufficiently difficult to ascertain; therefore it is not feasible to distinguish self-harm and attempted suicide for research purposes. This definition is not ideal as it does not cater for the differences between non-suicidal self-harm and genuine suicide attempts. However, the reporting of suicidal intentions may vary with the situation in which it is reported. The aftermath of self-injurious actions or potential implications of disclosure may influence the account of the experience. Nonetheless, this inclusive definition is perhaps the best definition to adopt for exploratory research.

The WHO/EURO study definition of parasuicide also refers to having the intention to act, and being interrupted before causing any harm (Bille-Brahe et al. 1994;Platt et al. 1992). This intended harm has been included in definitions for later studies (Rodham et al. 2004). However, if samples are recruited after participants harmed themselves it becomes even more difficult to gauge possible preventative intervention by other people on that or other occasions.

The assessment of self-harm varies with the definition adopted for research. Some studies assess a combination of whether a person has attempted "to hurt them self or end their life", rather than asking about non-suicidal self-harm specifically (Fergusson et al. 2000;Patton et al. 1997;Sourander et al. 2006;Steinhausen et al. 2006). This highlights the difficulty in researching self-injury per se. Some studies name behaviours and then ask about them separately; assuming participants differentiate self-harm from suicide attempts when asked about individually (Martin et al. 2005;Nock et al. 2006;Pearce & Martin 1994;Young et al. 2006). Other studies name the behaviours separately and analyse them together, as in the National Survey of Mental Health of Children and Adolescents in Great Britain which assessed trying to harm, hurt or kill yourself (Meltzer et al. 2001). Nock et al., (2006) note that suicide attempts and non-suicidal self-injury are distinguishable, yet highlight the fact that they do co-occur.

The WHO/EURO study adopted the approach that the terms *"parasuicide"* and "*attempted suicide"* should be used interchangeably, and this has been applied in subsequent research (Bhugra et al. 1999b;Haavisto et al. 2005). In the International Handbook of Suicide & Attempted Suicide, *"attempted suicide"* refers to any non-fatal self-injurious act, irrespective of suicidal intent, and is used interchangeably with the term *"deliberate self-harm"* (DSH), deliberate self-injury or deliberate self poisoning (Hawton & van Heeringen 2000;Kerkhof 2000).

In this thesis, the primary term used will be *"self-harm"*, defined as relating to any self-inflicted, non-fatal injury or overdose. With a particular interest in non-suicidal self-harm, the behaviours discussed for this thesis will be considered non-suicidal unless suicidal ideation is clearly expressed. This definition is adopted with the acknowledgement that the true intentions of the individual who self-harmed may never be identified after the event. It would be ideal to differentiate self-harm from attempted suicide for theoretical clarity, however that is quite difficult to do in practice. In the literature review for this thesis, it will be noted where previous research differentiates self-harm from attempted suicide.

The adoption of an inclusive definition such as that from the WHO/EURO multicentre study of parasuicide encompasses a wide range of behaviours. However, for the purposes of this study, non-specific poor self care, eating disorders and trichotillomania will be excluded from the definition of self-harm, despite the fact that they may serve a similar function for the individual (Diefenbach et al. 2002). This definition also excludes people who may not understand the meaning of their self-harm, due to poor mental health, or learning difficulties (Bille-Brahe et al. 1994).

This definition adopted for this thesis includes the possibility of self-harm being a form of experimentation, or risk taking akin to other health risk behaviours, such as alcohol, smoking or drugs (Patton et al. 1997). Suicidal thoughts or ideations will inevitably be discussed throughout this thesis, however, the main focus will be on exploring associations with acts of self-harm and unpacking the range of psychological and social factors proximal to that behaviour, not simply those relating to suicide.

2.3. Characteristics of self-harming behaviour

2.3.1. Methods of harming behaviour

The range of methods of self-injury further complicates the debate about defining self-harm. The method of self-injury may vary distinctly with conscious intention; to be found or not found, to inflict serious or non-serious harm, to make a visual statement, or to aim to be as secretive as possible. Alternatively, the relation of the method to the outcome of the harm may not be contrived at all (Lewinsohn et al. 1996;Silverman 2006).

Methods used for self-harm have been strongly associated with access to means, such as types of medication, poisons or weapons (Cantor 2000;Hawton et al. 2003b;Latha et al. 1996). This could vary with age, gender, time and place of residence. This issue has been the focus of research about availability of medication in the UK, such as paracetamol (Hawton et al. 1996;Hawton et al. 2001b;Hawton et al. 2003a;Hawton & Fagg 1992), and co-proxamol (Hawton et al. 2003b). Whereas in some countries, a change in accessibility to methods, such as paracetamol pack size in the UK, appears to have been associated with changes in suicidal behaviours (Hawton et al. 2001b), such associations have not

been shown in other countries (Cantor 2000). Other studies report the impact of such changes to have been short-lived (Gorman et al. 2007).

The definitions of study outcomes are likely to influence apparent trends. For example, studies exploring attempted suicides rather than self-harm tend to show a lower frequency of cutting and a higher occurrence of overdose or ingestion (Fergusson et al. 2003;Lewinsohn et al. 1996). This is important to consider while reviewing literature on self injurious behaviour.

Open-ended questions about self-harming behaviour used in quantitative community-based studies enable researchers, rather than the participants, to decide what is included and excluded as self-harm for their study. In the CASE study, open-ended question responses were categorised as: self-cutting, self-poisoning, self-battery, consumption of a recreational drug, jumping, burning, strangulation or hanging, ingestion of a non-ingestible substance or electrocution, according to the Lifestyle and Coping Skills Survey Guidelines (Hawton et al. 2006;Madge et al. 2008). In the Victorian Adolescent Cohort Study in Australia, self-harm was coded and interpreted by mental health professionals as 'self-laceration', 'self-poisoning', 'deliberate recklessness', or 'self-battery' (Patton et al. 1997). Additional criteria clearly indicating suicidal intentions were considered to indicate a genuine suicide attempt, distinct from self-harm. Inter-rater agreement was relatively high in the Australian study, suggesting confidence can be placed in this style of assessment.

Multiple methods of self-harm

Methods for self-harm are not mutually exclusive and people who injure themselves in one way may also injure themselves in other ways (Bhugra et al. 2003;Hawton et al. 1996;Hawton et al. 2003a;Muehlenkamp & Gutierrez 2004;Ross & Heath 2002).

2.3.2. Reasons why young people self-harm

Self-harm serves a wide variety of functions, a large proportion of which are an expression of emotional turmoil (Kerkhof 2000). The actions may be aiming to achieve a certain goal, or expression, seeking relief or escape, and the motivations may be conscious or unconscious (Michel 2000). There are a plethora of reasons why young people may self-harm. Is it to attempt suicide? Is it to express something they find inexpressible? To send a message to someone else, or to escape? Is it to experiment, to feel a sense of

achievement or sense of control? Self-injurious behaviours could have multiple motives; some sustained, some transitory (Kerkhof & Arensman 2000). Motivations could feasibly be contradictory; such has hurting themselves to feel justified in looking after themselves.

Many people who self-harm view their actions as a means of surviving, coping, or reducing negative emotions such as frustration or depression, rather than as acts intending to end their lives (McLaughlin et al. 1996;Pattison & Kahan 1983;Rodham et al. 2004;Ross & Heath 2002;Williams 1997). However, assuming that non-serious self-injury is not suicidal may lead to the true suicidal intentions of some self-injury being overlooked, as hypothesised by Horrocks et al. (2003). They note that individuals who self injure are less likely to receive specialist follow-up or have thorough psychosocial assessments than self-poisoners. Studies which do not differentiate attempted suicide from other forms of self-harm imply at least the possibility that the act may be in some way suicidal.

Community-based research

Research with community-based samples of young people provides evidence for a range of functions or reasons for self-harm. The primary reasons for self-harm in an English school-based sample (Rodham et al. 2004) were to 'to get relief from a terrible state of mind', 'to punish themselves' and 'to show how desperate they were feeling', thus seeking a form of expression and relief. The young people who had poisoned themselves were more likely to have expressed a wish to die than those who had cut themselves. Both those who had cut and poisoned themselves reported less appeal to others in their motivations, not necessarily seeing their harm as seeking attention or help from others. The combined results from the European CASE study reported that the most common reason to self-harm was 'to get relief from a terrible state of mind', followed by wishing 'to die' (Madge et al. 2008).

2.3.2.1. Functions and outcomes of self-harm

The function of self-harm also relates to the expected outcome of such actions. People who self-harm may not be able to offer an explanation of how their harming brings relief, only that it does, implying an element of dissociation (Mental Health Foundation 2006). This simplicity in explaining self-harm may relate to the function that harm serves for certain individuals. For example, the Mental Health Foundation report described young people not comprehending the motivations for and impact of their self-harm, or that self-harm helped them feel better when other things they had tried had not helped.

The function of self-harm reported in research may be influenced by the type of assessment used, how open the questions were to interpretation, and how participant responses were interpreted by the researcher. For example interview data requires interpretation of accounts by the researcher, and this may vary depending on the theoretical persuasion of the researcher. A sociological view may relate harming behaviour to external triggers, with the placing an emphasis on the circumstances leading them to self-destructive actions (Redley 2003). In contrast, a psychodynamic approach may see the harm as stemming from the individual's inner world, hurting the self in response to an overbearing superego, or as an attack on an introjected object (Bell 2000). Theoretical explanations of self-harm will be discussed further in section 2.7.

2.4. Rates and variation in adolescent community samples

Due to variation in definitions and methods of assessment, comparisons of prevalence between countries or even regions need to be conducted with caution (Cantor 2000). Studies such as the WHO/EURO multicentre study of parasuicide in adults (Bille-Brahe et al. 1994;Platt et al. 1992) and the adolescent CASE study (Hawton et al. 2002) facilitate international comparisons as standardised criteria have been applied in different centres. Kerkof (2000) queries the validity of population-based studies of self-harm in adolescents as they do not assess prevalence in non-respondents, and also highlights that question wording is imperative, as asking about attempted suicide may imply intent, absent from other forms of self-harm. However, not mentioning the possibility of suicidal intent may exclude those who perceived their actions as a suicide attempt.

The time span of prevalence ratings also influences reported rates. Lifetime prevalence assessments could give a rating of the breadth of the issue; however they may be open to criticism for recall bias. Reports of time-limited prevalence could perhaps give a more clearly defined rating, with less influence of recall bias, however they do not provide information about the longer term issues (Ross & Heath 2002). There are benefits in reporting both sorts of data, and with regards to self-harm, both lifetime and time-limited prevalence provide pertinent information. The following section details rates from adolescent community-based self report studies, firstly where the emphasis was on 'self-harm', followed by studies where self-harm and attempted suicide were not distinguished.

2.4.1. Adolescent community-based research on self-harm

Hawton and James (2005) claim that 7-14% of adolescents will self-harm at some time in their life. Community-based studies of self-harm or self-injury with representative adolescent samples indicate a range in the lifetime prevalence for 15-16 year olds varying with study location, self-harm assessment and definition. For example, lifetime prevalence was 12.2% in Southern Ireland (Sullivan et al. 2004), 12.4% in Queensland, Australia (DeLeo & Heller 2004), 13.2% in Oxford, England (Hawton et al. 2002), 15.9% in the Midwest, United States (Muehlenkamp & Gutierrez 2004) and 18.7% in South Australia (Martin et al. 2005). The West of Scotland Study reported a lifetime prevalence of 7.1% for self-harm by any method and 4.1% for lifetime self-harm by cutting, scratching or burning, in their 19 year old sample (Young et al. 2006). In a single school study, Pearce and Martin (1994) reported a lifetime prevalence of 30% of 15-16 year olds having ever tried to hurt themselves, a high rate compared with other studies.

The influence of qualifying self-harm beyond a binary question is illustrated by studies where prevalence is given for a simple assessment and also a more comprehensive assessment. Qualification of simple response questions was adopted by the CASE study, a multicentre study of 15-16 year olds, where anonymous open-ended descriptions of self-harm were classified using a standardised coding manual; personal communication; later published in Hawton et al. (2006). The reported rates were similar across countries, with a 12 month prevalence of 8.6% in England, 8.4% in Australia, and 9.3% in Ireland for the simple question about having self-harmed. When coded to meet study criteria, the 12 month prevalence of self-harm with a confirmed method of harm dropped to 6.9% in England, 6.2% in Australia, 6.6% in Norway and 7.5% in Ireland (DeLeo & Heller 2004;Hawton et al. 2002;Sullivan et al. 2004;Ystgaard et al. 2003). These were the rates in peer reviewed publications at the time this review was conducted. The rates for each study centre were modified for later publication together, reported in Hawton et al. (2006).

Differences in the detail of reports of self-harm may reflect reluctance by participants to disclose details about their self-harm, or imply that the simple (Yes/No) question about self-harm lacks specificity. This was illustrated again in a community study where adolescents who reported lifetime self-mutilation in a screening questionnaire were interviewed subsequently, lifetime prevalence of non-suicidal self mutilation was substantially lower at interview (Ross & Heath 2002). This difference may be a consequence of the method, with fewer people willing to discuss their experience face-to-

face compared with a questionnaire. Alternatively this may indicate false positives in response to the screening questionnaire assessment.

The twelve month prevalence in a longitudinal community-based study of self-harm in Australian adolescents was reported to be 5.1% (Patton et al. 1997). The lower rate in the longitudinal study may reflect sample attrition or a bias in the sample who repeatedly participated in the study. Alternatively, it may also be lower due to the possibility of being followed up, compared with the possible anonymity afforded by cross-sectional studies. It has been noted that higher rates tend to be reported in studies where the participants are anonymous, compared with non-anonymous studies (De Wilde & Kienhorst 1994;Langhinrichsen-Rohling et al. 2006).

2.4.2. Adolescent community-based research on self-harm combined with suicide attempts

Longitudinal research: Lifetime prevalence

Numerous studies combine assessment of self-harm and attempted suicide, and these rates are generally lower than rates for self-harm alone. Rates vary between studies. Longitudinal studies show the lifetime prevalence at age 15-16 to be 2.7% in a mixed gender sample from New Zealand (Fergusson et al. 2000); 3.8% for boys, and 7.1% for girls at age 15 in a Australian school-based study (Martin et al. 2005). A mixed gender rate of 7.1% for lifetime suicide attempts or doing something that could have killed them was shown in Oregon, USA adolescents (Lewinsohn et al. 1996). In a nationally representative sample of Norwegian adolescents 8.2% reported attempting suicide (Wichstrom 2000). The Australian and New Zealand studies mentioned above assessed self-harm and attempted suicide. Reports reflect the assumption that participants would differentiate between self-harm and attempting suicide when responding to separate questions. Lifetime suicide attempts were reported by 4.2% of 18 year olds in an American longitudinal study (Reinherz et al. 1995). In a 19 year old sample from Scotland (Young et al. 2006), lifetime attempted suicide was reported by 6.4% of the sample, and this was highly correlated with reports of self-harm (r=0.59).

Cross-sectional research: Lifetime prevalence

Lifetime prevalence of attempted suicide also varied in cross-sectional studies. Rates of suicide attempts reported from single school studies include 5.6% in the mid-West of

America (Muehlenkamp & Gutierrez 2004) and 8.7% in New York, 9% in a single school study in South Australia (Pearce & Martin 1994). In studies involving larger samples, attempted suicide has been reported by, 8% in Dublin adolescents (O'Sullivan & Fitzgerald 1998) and 10.5% in a five school study in Houston, USA (Roberts et al. 1997). A Dublin study also conducted interviews when participants reported suicidal behaviour; the reported lifetime prevalence of 2.3% at interview was substantially lower than the 8% from the screening questionnaire. The authors interpreted this as being influenced by questioning of confidentiality, and also relating to false positives in screening questionnaires (O'Sullivan & Fitzgerald 1998).

1-2 year prevalence of attempted suicide

Prevalence varies within shorter term assessments of attempted suicide. One year prevalence of attempted suicide was reported in the National Longitudinal Study of Adolescent Health (Add Health) in America as 4% at Time 1 in participants aged 11-21, with a median age of 16 years (Hallfors et al. 2004), 3.6% at Time 2, 11 months later (Borowsky et al. 2001). The one year prevalence of suicide attempts in a national survey in Switzerland was 3% (Rey Gex et al. 1998). Higher rates were evident in the Youth Risk Behaviour Survey, a national school-based survey in the United States, with the national results (Miller & Taylor 2005) and results from South Carolina (Garrison et al. 1993) showing that respectively, 7.7% and 5.9% of the samples had made an attempt that did not require medical attention in the past 12 months, and that respectively 2.3% and 1.6% reported making an attempt that did require medical attention. Very high rates of suicide attempts were reported in a community study of adolescents in New Hampshire, with 15% having made one or more attempt in the past year (Rosenberg et al. 2005). The two year prevalence of suicide attempts was reported as 2.7% in a representative Norwegian sample aged 12-30 (Wichstrom 2000).

The prevalence results vary greatly between studies, potentially influenced by the type of questions asked, the method of data collection, time span of the assessment and the definition of self-harm compared with attempted suicide. Rates of attempted suicide tended to be lower than rates addressing non-suicidal self-harm, or when the two were combined. Results from community-based studies in this review showed numerous studies reporting over 10% of young people aged 15-16 years had ever self-harmed when asked a simple question about it. Although this rate was lower when more detail was explored, community studies consistently showed more than 5% of 15-16 year olds had hurt themselves, supporting the notion that this is a common behaviour in young people.

2.4.3. Prevalence of self-harm by method of harm

The reported prevalence of different methods of self-injury is greatly influenced by the study type. Data from community-based samples shows self cutting and scratching as the most prevalent forms of self-harm. Such harm may not be severe enough to warrant accessing medical services. In an English secondary school sample, self cutting was reported in 64.4% of those who had self-harmed, compared with 30.7% of young people who had self-harmed reporting self-poisoning (Rodham et al. 2004). Similar results have been reported in an Australian adolescent community-based sample, where 59.2% of those who had self-harmed had cut themselves, compared with 29.6% who had overdosed on medication. Other methods were less prevalent, including illicit drug use (3%), self-battery (2.2%), hanging (1.7%) and inhalation (1.7%) (DeLeo & Heller 2004). Patton et al. (1997) reported self laceration and deliberate recklessness as the most prevalent types of self-harm, followed by self poisoning in their adolescent school-based study.

As some studies of samples recruited through services have been included in this review, it is worthy to note a key difference in methods of self-harm. Self poisoning is reported as the most common method used in studies with samples recruited following presentation at hospital for young people (Bhugra et al. 2004;Hawton et al. 1996;Kienhorst et al. 1995). Community-based research indicates that presentation to hospital is a rare outcome for self-harm (Hawton et al. 2002). As multiple methods of self-harm may be used with varying levels of severity, only the most medically serious may require treatment.

2.4.4. Self-harm at different ages during adolescence

This section will outline patterns of self-harm reported at different ages during adolescence. Evidence has been taken from both community and service-based research for this section. The prevalence of self-harming behaviour increases in mid-adolescence. Hawton et al. (1996; 2003a) report that presentations to hospital are rare under the age of 12 years, however the behaviour becomes increasingly prevalent between 13 and 16 years. Hawton et al. (2003a) note that the relative rarity of self-harm under the age of 12 years may imply that the onset of harming behaviour may relate to puberty.

There is some evidence that self-harm which does not involve hospital presentation emerges later than age twelve. For example, in a community-based study with participants

whose average age was 15 years; of those who had self-harmed, around one tenth had started within the past year, more than half had started two years earlier, a quarter started to self-harm three or more years earlier. Other participants could not recall when they had started (Ross & Heath 2002). Muehlenkamp and Gutierrez (2004) also cited an older age of onset, with self-injury most commonly starting at age 14, although the age of onset ranged from 5-17 years in that study.

The rate of self-harm reportedly increases throughout mid-adolescence with some evidence for a peak around age 15. In a review by Brent (1995) on self-harm and attempted suicide, rates for females increased greatly in mid-adolescence. In a community-based cross-sectional study, the lifetime prevalence of self-harm or attempted suicide in adolescents aged 14 years and older was significantly higher than those younger than 13 years (Roberts et al. 1997). The same study reported significantly higher odds for suicide attempt in the past two weeks for adolescents aged 15 years or older in multivariate analysis, compared with participants aged 12-14 years. In an Australian community-based study, the prevalence of self-harm in 13-15 year old males appeared relatively constant, with a slightly higher rate at age 14. For girls, however, self-harm was more frequent in 15 year olds, compared with 13-14 year olds (Martin et al. 2005). A peak in self-harming behaviour has been reported around the ages of 15-16 years, compared with slightly older adolescents in The Netherlands (De Wilde & Kienhorst 1994). A community-based cross-sectional study in Southern Ireland indicated no difference in prevalence of self-harm in participants aged 15-17 years (Sullivan et al. 2004).

Discussion of prevalence in school-based research requires consideration of potential biases in the population from which samples have been drawn. The Youth Risk Behaviour Survey showed a higher incidence of attempted suicide in 15-16 year olds compared with older adolescents; however, it is conceded that school-based studies may have a selection bias as less healthy adolescents may not attend school in later years (Shaffer & Gutstein 2002). Other studies argue that school-based samples of people aged 15-16 years are likely to be representative as most adolescents that age still attend school (Evans et al. 2005).

2.4.5. Self-harm and attempted suicide by gender

The majority of community-based studies illustrate that adolescent females have higher lifetime prevalence of both self-harm (DeLeo & Heller 2004;Hawton et al. 2002;Martin et al. 2005;Ross & Heath 2002;Sullivan et al. 2004) and attempted suicide than males (Fergusson et al. 2000;Meltzer et al. 2001;Reinherz et al. 1995;Roberts et al. 1997;Sourander et al. 2001;Stewart et al. 2006;Wichstrom & Rossow 2002). In his review, Brent (1995) noted that the rates of suicide attempts were similar in younger adolescents, and the gender difference increased with age through adolescence. For example, the 1999 National Survey of Mental Health of Children and Adolescents in Great Britain collected data on a representative sample of children and adolescents in England, Scotland and Wales (Meltzer et al. 2001) and found that 7.9% of girls and 5.3% of boys aged 13-15 had self-harmed or attempted suicide. For the purpose of this review, the self reported rates and associations with self-harm in 11-15 year olds will be discussed, rather than rates from parent report in The National Survey of Mental Health of Children and Adolescents in the UK (Meltzer et al. 2001). Fergusson et al. (2000) reported that 3.1% of females and 0.8 % of males had attempted suicide by 16 years in New Zealand.

The 12 month prevalence results in adolescents also indicated that females were more likely to self-harm (Patton et al. 1997) and attempt suicide (Borowsky et al. 2001;Hawton et al. 2002;Rosenberg et al. 2005;Wichstrom & Rossow 2002). For example, Patton et al. (1997) reported that 6.4% of females and 4% of males had harmed themselves in the past year. Looking at attempted suicide, the Add Health study reported a 12 month prevalence of 5.1% for adolescent females compared with 2.0% for males (Borowsky et al. 2001;Resnick et al. 1997).

Variation is also evident in large scale studies reporting odds of males and females who had self-harmed or attempted suicide. A nationally representative study of Norwegian adolescents (Wichstrom & Rossow 2002) noted that the odds ratios for being a female making a suicide attempt remained stable at 1.7 for lifetime (reported at Time 1) and 12 month prevalence (at Time 2). Lower adjusted odds of 1.46 (95%CI 1.10-1.93) were reported in a national survey in the UK (Meltzer et al. 2001), and higher odds of 3.9 (95%CI 3.1-4.9) were reported for females from an English community sample, compared with males (Hawton et al. 2002). The extent of gender differences in self-harm may vary across countries; however, it is also feasible that differences in odds ratios may stem from

studies adjusting for different factors in their multivariate analyses, or differences in confounders relevant for different groups.

There have also been studies reporting no gender differences. Two small adolescent studies in Ireland and Australia found no significant gender difference in lifetime prevalence of self-harm or suicide attempts (O'Sullivan & Fitzgerald 1998;Pearce & Martin 1994). Muehlenkamp & Gutierrez (2004) reported no significant gender differences in *self-injury* in an adolescent school-based sample; however there was a significant difference in gender for *attempted suicide*, with more females then males attempting suicide. Roberts et al., (1997) reported a trend in the opposite direction in their school-based study, with males having a higher 2-week prevalence of suicide attempts. In a study on non-suicidal self-injury in an adolescent inpatient sample, Nock et al., (2006) reported no gender difference in the number of episodes of self-harm or the number of methods used, however, females reported more lifetime suicide attempts than males. This is in contrast with the higher rates of completed suicide among young males (Cantor 2000).

2.5. Repetition and cessation of self-harm

Repeated self-harm is frequently reported by young people, through both retrospective questions (Evans et al. 2005;Hawton et al. 2002;Patton et al. 1997) and prospective studies at a community level (Borowsky et al. 2001;Sourander et al. 2006;Wichstrom 2000). Longitudinal studies illustrate that self-harm is a predictor of later self-harm. For example, in a Finnish longitudinal study, harm at age 12 predicted suicidal behaviour at age 15 (Sourander et al. 2006). The Add Health study in the United States reported significantly increased odds for attempted suicide at Time 2 for young people in grades 7-12, if a previous suicide attempt had been recorded at Time 1, 11 months earlier (Borowsky et al. 2001). In terms of repetition rates, 21.9% of a representative Norwegian adolescent sample who admitted making a suicide attempt in the follow-up had also reported an attempt in the first phase of the study two years earlier (Wichstrom 2000).

Assessment of multiple episodes of self-harm varies, and thus differences in repetition rates may emanate from genuine differences between groups, or simply differences in research methods. Of the adolescents who reported self-harm in cross-sectional community-based studies, previous or repeated self-harm was reported by 15% in a large American study (Rosenberg et al. 2005), 30% in an Australian study (Patton et al. 1997),

54.8% in an English study (Hawton et al. 2002), and 63.6% in a small American study (Harkavy Friedman et al. 1987).

Associations with repetition of self-harm

Issues associated with repetition in adolescent self-harm have been explored at a community level (Evans et al. 2005;Rosenberg et al. 2005). In a community sample, depressive symptoms, weight problems, use of hard drugs and heavy alcohol use were associated with repetition (Rosenberg et al. 2005). A recent English study reported that females who had repeatedly self-harmed were less able to talk to their relatives compared with those who had a single episode; and males who repeatedly self-harmed were less able to talk to their mothers than those who had self-harmed only once (Evans et al. 2005).

Further exploration is required into why people repeatedly self-harm, along with enquiry into the cessation of self-harm after repeated episodes. Sinclair and Green (2005) qualitatively explored these issues with adults who had not self-harmed for at least two years, finding that cessation in self-harm related to resolution of identity or adolescence related stressors, a reduction in heavy alcohol usage, or acknowledgement of mental health problems which had been undiagnosed at the time of their self-harm. This study implied that with resolution of such situations, there was no longer the need for self-harm, but while those circumstances continued, self-harming behaviour was maintained.

Repeated self-harm may be an ongoing response to the circumstances in which self-harming begun. Alternatively the reasons for repetition of self-harm may change and develop once the behaviour pattern has been established. Repeated self-harm over a finite period of time may or may not have a unified aetiology; however, it is worth exploring in further research.

2.6. Help-seeking and disclosure

2.6.1. Disclosure of self-harm

Self-harm is often a highly personal and secretive behaviour, despite the fact that behaviours such as cutting and burning are likely to leave physical marks or scars and that more serious attempts may lead to attention from medical services. It is noteworthy that

there is a qualitative difference between the behaviour being found out, or actively disclosed to another person.

There is also a qualitative difference between certainty and the possibility that others may be aware of self-harm. In a community sample of 15-16 year olds in England, 78.9% of those who had self-harmed believed that someone else knew about their harm on the last occasion (Evans et al. 2005). Other community-based adolescent samples indicate that disclosure of self-harm is infrequent. Patton et al. (1997) noted that 14% of adolescents in their study who had self-harmed informed someone else before the episode, and 25% reported the event to others afterwards. Around one third of adolescents in a small American study claimed to have told someone about their attempt before they had made it, and over one third had not told anyone about it afterwards (Harkavy Friedman et al. 1987). Similarly, in a national survey in Switzerland, 40% of the adolescents who had attempted suicide in the past year had disclosed their attempt to a friend or relative (Rey Gex et al. 1998). Young people claimed that they would be most likely to seek support from friends (Coggan et al. 1997;DeLeo & Heller 2004;Evans et al. 2005;Fortune & Hawton 2005a). These results may indicate differences between young people actively disclosing their self-harm, as opposed to it being discovered by others, or merely believing that other people might know about their harm.

Reluctance about disclosure or help-seeking could relate to negative experiences when previous self-harm had been disclosed and also fear of the response they might receive following their admission (Coggan et al. 1997;Mental Health Foundation 2006). Disclosure of self-harm was also reported as disempowering the young person, as they might lose control over who knew about their self-harm. Attempts to reduce harming by others may cause distress to the person hurting him or herself, as that may have been a key coping strategy (Mental Health Foundation 2006).

The experience of being told about self-harm by a friend, family member, or even as a health professional is also challenging (Anderson et al. 2003;Coggan et al. 1997;Mental Health Foundation 2006). Social relationships may change, and that might alter the situation for the young person who had self-harmed. The exposure to self-harm may induce anxiety in others, especially if there is difficulty understanding why those actions may have been taken (Anderson et al. 2003;Mental Health Foundation 2006). Reports

from hospital staff indicate that working with young people who self-harm could be both difficult and upsetting (Mental Health Foundation 2006).

2.6.2. Help-seeking

Closely related to issues of disclosure are those concerning help-seeking after self-harm. Disclosure may involve telling another person about self-injury, or the injury being discovered. Seeking help will be discussed as a more specific form of disclosure; that is, making self-harm known to others with the aim of seeking assistance. There are many obstacles deterring young people from seeking formal help, as evidenced by the preference for disclosing distress to friends or family, or adopting more isolative strategies (Fortune & Hawton 2005a). The act of self-harm may also imply a difficulty in communicating distress in more usual ways. The stigma associated with self-harm or attempted suicide may also prevent people from seeking help. As exposure to self-injurious behaviour may distress others, it may inhibit people who have self-harmed seeking help (Stewart et al. 2006).

The adolescent community-based literature indicates that although young people who self-harm may perceive the need for help, they are still reluctant to seek it, when compared with young people who had not self-harmed (Evans et al. 2005). Young people reported a lack of knowledge about services as a reason for not seeking help. However, despite the fact that participants in that study acknowledged pathways towards seeking help, there was concern about the level of trust and confidentiality assured when talking with school counsellors. Services such as psychologists and psychiatrists were deemed too difficult to contact, too impersonal and too expensive (Coggan et al. 1997). In contrast, young people who contributed to the UK National Inquiry into Self-harm reported seeking help as beneficial (Mental Health Foundation 2006). Reports about satisfaction with services vary with the source of information or participant recruitment, insofar as young people actively volunteering to a study such as the National Inquiry into self-harm may constitute a different group to an anonymous community-based sample or those recruited following service use.

The National Institute of Clinical Excellence (NICE) has produced guidelines (National Institute for Clinical Excellence 2004) for responding to self-harm in primary and secondary

care. However, the National Inquiry noted that these have not yet been evaluated, so adherence to these guidelines remains unclear (Mental Health Foundation 2006).

In an English community-based study, less than half of the adolescents who had self-harmed in the past year tried to seek help before harming, and slightly more than half had received help following their most recent self-harm. Females were significantly more likely to seek help than males but there was no significant difference in help received (Evans et al. 2005). Limited help was sought from mental health services or GPs by Australian adolescents who had self-harmed, with a preference for informing friends or family (DeLeo & Heller 2004). This study reported no gender difference in help-seeking prior to self-harm.

A minority of young people who self-harm also report seeking medical help. In school-based studies, the percentage of those who had self-harmed requiring medical treatment is consistently low. For example, the multi-centre CASE study reported that of those who harmed themselves in the past year, 14.7% in the Norwegian study (Ystgaard et al. 2003), 10.5% in the Australian study (DeLeo & Heller 2004) and 12.6% in the English study (Hawton et al. 2002) were treated in hospital. In the Irish section of the CASE study, of the participants who self-harmed, help from any service was accessed by 11.1% prior to the self-harm episode, 15.3% after the episode; and actual hospital presentation was only made by 11.3% of those who had self-harmed (Sullivan et al. 2004). A slightly higher rate (15%) of 18 year old Finnish males in a community sample who had self-harmed in the past 6 months had sought help from services (Haavisto et al. 2005).

Rates of help-seeking appear higher in studies examining attempted suicide and self-harm with a greater proportion of suicide attempts receiving help. In the Youth Risk Behaviour Survey in South Carolina, 5.9% of that sample reported self-harm without input from medical services and 1.6% of the entire sample reported making a suicide attempt that required medical services (Garrison et al. 1993). Similarly, different rates of help-seeking were reported from a cohort study in New Zealand, where 7.5% of their adolescent sample had made a suicide attempt, and of those attempts, 29% received medical attention (Fergusson et al. 2000). These assessments of help-seeking for attempted suicide are higher than rates of help-seeking reported in community research on self-harm in the CASE study (DeLeo & Heller 2004;Hawton et al. 2002;Ystgaard et al. 2003).

It is unclear whether the young people who come to the attention of medical services represent those hurting themselves in more serious ways, those with a more open attitude

to seeking help, or some combination of the two. Consideration must also be given to whether participants in a study have sought help as study recruitment may bias results (Bhugra et al. 1999c). Having received some form of treatment for mental health was a significant predictor of self-harm 12 months later for girls in a community adolescent sample (Borowsky et al. 2001).

2.7. Theories and models of self-harm

A range of theories relating to self-harm will be outlined in this section. The variety of behaviours and motivations encompassed by self-harm provide a challenge on a theoretical level, as well as at an operational level for conducting research. It is feasible that some theoretical models may have a better 'fit' for specific types of self-harm, however, there are likely to be underlying similarities describing the behaviour. Understanding self-harm requires the behaviour to be viewed within a psychosocial framework (Michel 2000), including social context, culture, life events, along with biological and psychological aspects of the individual's life.

Psychological models of self-harm revolve around an individual's propensity to injure him or herself and the psychological factors which lead to this type of action, dismissing external triggers as somewhat superficial (Bell 2000). It is, however, difficult to disentangle the roles of internal and external factors. For example, in Williams' discussion of entrapment, it is the individual's perception of being unable to escape situations and feelings which related to self-injurious and suicidal behaviour (Williams 1997).

Psychodynamic theory emphasises the intrapsychic tension, allowing for a variety of different ways of attacking the self. For example, aggressive self-destructive behaviour has been associated with a wish to die, to kill and be killed (Apter et al. 1995). This explains how non-depressive self-harm may be a reaction to anger and conflict, expressed through self destruction. Pattison and Kahan (1983) extend this further and refer to self-injury as a 'masochistic surrender' following a crisis.

In terms of object relations, self-harm could be seen to stem from the introjection into the ego of a hated object which is then attacked. Harming and torturing the self function as punishment, and at the same time, attack the internalised element of another (Bell 2000). The attack could also function as a rebuke against the self for the desire to hurt the

introjected object, or a response to the loss of an object. The role of self-harm is also described as a means of relieving the pressure from an overbearing, vengeful superego (Bell 2000). The release of the psychic tension may be paralleled in the release of the blood from the skin, and have a more existential role, eliciting a sense of being, and existence in the world.

Applying attachment theory, self-harm may stem from an accumulation of experience with unmet interpersonal needs throughout childhood and adolescence (Bowlby 1988;Tyrer & Steinberg 1998). This may lead the young person to act in a way that had previously elicited attention and care, for example displaying child-like behaviours, or presenting a physical injury which would require care. Self-harming behaviour may involve some form of manipulation to gain love, or inflict punishment. The empirical associations between self-harm and violent behaviour are consistent with the view that self-harm is a form of violence, turned upon the self rather than directed outwardly, or at another person (Borowsky et al. 2001;Miller & Taylor 2005).

Identity and a sense of self, particularly in adolescence, have been associated with self-harm. It could be that the young person self-harms to express conflict between an intrinsic and extrinsic self; seeking validation from others, he or she may adopt secretive maladaptive coping strategies while publicly presenting a 'front' or 'other self' (Adams et al. 2005). Self-harming may also function as a tangible means of developing a 'sense of self'. Developing an identity as '*someone who self-harms*' may also play a role of reinforcement for future behaviour, yet it does not necessarily explain the initiation of self-harm among young people (Anderson et al. 2004).

Behavioural models would explain self-harm as a learned maladaptive response, repeated through positive reinforcement of previous self-harming (Tyrer & Steinberg 1998). This may well play a part in repeated self-harm, but again, it does not clarify the means by which self-harming behaviour is initiated or triggered.

A cognitive model would propose that actions of self-harm relate to thoughts and beliefs. The behaviour stems from the perception and appraisal of a situation, with self-harm as an appropriate response. Self-harm as a coping strategy to keep living may not involve suicidal ideation, however, others may be looking for escape or death as a way of dealing with current problems. Lazarus and Folkman (1988) propose that individuals experience stress as an emotional response to their interaction with the environment, and the

strategies employed to deal with stress are part of a dynamic relationship between beliefs held about the experience and their own capacity to react. Coping style and assessment of how appropriate a coping strategy is in response to stressors will influence whether or not that particular strategy is adopted or rejected (Lovallo 1997). Self-harm or attempting suicide could be seen as maladaptive responses to extreme stress.

Emotion-focused coping has been reported in people who self-harm. This relates to people feeling unable to address or solve problems, and instead focusing on their feelings and more avoidant behaviours (Evans et al. 2005;McAuliffe et al. 2006). McLaughlin et al., (1996) reported dysfunctional coping in their study of adolescents who had overdosed and presented to hospital. Participants in that study reported that overdoses would help them escape problems for a while, would prompt other people to help them, or stemmed from a perceived lack of options to resolve distress.

For a coping response to be required, the individual must perceive some form of stress. Self destructive responses to stress may stem from a background susceptibility, predisposition or personality type, as proposed in the stress-diathesis model (Mann et al. 1999). For those who do not repeatedly self-harm, or only do so for a limited period, the reduction in distress achieved through self-harm may have been an experimental way of coping, and may not be required once the stressful situation is resolved (Ross & Heath 2002;Sinclair & Green 2005).

The medical, or disease model relies on the premise that mental health problems are a manifestation of an illness, involving chemical and physiological disturbance in the body (Tyrer & Steinberg 1998). A behavioural phenomenon such as self-harm, could be understood within a model of mental health and illness (Anderson et al. 2004), with suicidal behaviours being secondary to a psychiatric disorder. Self-harming behaviours are categorised in the ICD-10, as noted in section 2.2 (World Health Organisation 2006). However, attempted suicide is not a category of illness. It is possible that psychopathology may not be a necessary for someone to self-harm, however, there is evidence from population-based research in the UK that adults do not attempt suicide in the absence of a psychiatric disorder (Jenkins et al. 2005).

More sociological models would explain self-harm as a function of the environment and social context leading an individual to behave in that manner. Redley (2003) outlined a model of self-harm which portrayed people who self-harmed as having a limited capacity

to change their lives, coupled with the belief that they could not have acted otherwise. The implication is that should the same situation arise again, circumstances would be lead to the same actions. This model does involve the individual's motives and intentions, however, the influence of context plays a major role.

If self-harm is viewed as a response to seemingly insurmountable difficulties, it may be repeated, functioning as an acceptable response to the individual's internal world and social circumstances (Michel 2000). An integrated model would view self-harm as involving agency; choosing to act in response to a crisis given an individual's current health, socio-cultural context, background and life experiences. There may also be different cultural approaches to stressful situations, and variations in acceptable ways of reacting to a situation or experience.

Some studies propose that a number of models are appropriate for theoretically explaining self-harm. One such study is the Christchurch Health and Development Study conducted in New Zealand. The authors note that mental health is a strong predictor of suicidal behaviour, however mental health is also viewed as a mediator between exposure to social and individual stresses. This also provides evidence for an accumulative risk model, showing that with increasing exposure to risk factors across domains there is an increased risk of suicidal behaviour (Fergusson et al. 2000). This cumulative risk factor model has been adopted in other epidemiological research in this area (Lewinsohn et al. 1996;McKeown et al. 1998;Reinherz et al. 1995). However, although mental health is strongly associated with suicidal ideation and attempts, the majority of young people who had depression did not make suicide attempts. This outcome was mediated by other influences, implying that it is the combination of factors making a person vulnerable, possibly in addition to depressive symptoms, which are likely to lead a young person to a suicide attempt (Fergusson et al. 2003).

The research in this review will encompass individual, social and behavioural associations with self-harm, therefore accepting the associations between self-harm and risk factors at individual, peer, family and community levels (Borges et al. 1995). Although this assumes the risk factor model is valid, the impetus from the individual to hurt him or herself is viewed as equally important.

2.7.1. Adolescence and identity development

As this thesis focuses on self-harm in young people, this section will provide a brief discussion of adolescence and identity with respect to conducting research. Adolescence is the period involving a transition between life as a child and that of an adult (Smith et al. 2003), and thus it is without the innocence of childhood or the responsibility of adulthood (Shaffer 1999). It is a time of change in identity; with physical maturity, increasing independence from family, and clarification of independent thought, personal and social values (Coleman 1995). This change could also include a heightened awareness of an adolescent's own image, identity, and appearance to others, all of which could involve novelty, confusion and awkwardness (Anderson et al. 2004;Smith et al. 2003).
Although transition through adolescence is a smooth process for the majority of young people (Coleman 1995), some young people find the changes overwhelming (Briggs 2002). If self-harm was a feature of adolescent life, it may be adopted as a key part of their identity (Anderson et al. 2004).

The roles assumed through adolescence leading into adulthood also are culturally defined, and thus there is scope for variation in the interpretation of this term amongst cultural different groups (Bhugra 2004;Briggs 2002;Shaffer 1999). Adolescence has potential to be a time of great conflict, where the values young people wish to adopt clash with those of their parents. In more collective cultures, the separation from one's family may not be as acute as in individualistic cultures (Stewart et al. 2006).

2.8. Social and Psychological factors associated with self-harm

This section presents a review of the literature pertinent to the studies conducted for this thesis. The emphasis is on psychological and social factors relevant to self-harm in adolescents living in multi-ethnic communities. The topics covered in this section informed the development of hypotheses for the quantitative study (Chapters 4-5) and the research objectives for the qualitative research (Chapters 6-8). This will not be an exhaustive account of social and psychological associations with self-harm, as many factors are beyond the scope of this research. For this research, "social factors" relate to interpersonal relationships, the location of the study and groups of people within that area, such as East London and the influences of culture. "Psychological factors" refer to issues pertinent to the individual, including mental illness or common mental disorder, such as depression

and anxiety, along with coping with stress. The notion of identity is infused in both social and psychological factors to be explored in this thesis. Ethnicity and culture will be presented in section 2.9, and also discussed alongside other factors, if ethnic or cultural differences were reported in previous research. The role of both ongoing and recent factors need to be considered in researching self-harm and attempted suicide (Beautrais 2000).

2.8.1. The role of ongoing stressors

Self-harm could be viewed as a response to a complex mixture of ongoing stressors with or without additional short-term triggers (Fergusson et al. 2000;Fox & Hawton 2004). Combinations of adverse experiences such as individual vulnerabilities, childhood or family adversity, negative life events, mental health problems or specific cultural, social or contextual factors may influence the likelihood of suicidal behaviours in adolescence (Beautrais 2000).

When researching this type of behaviour, consideration must be given to the context and background predisposition of the individual as well as the immediate, short-term stresses or circumstances. Ross and Heath (2002) assert that the variation in frequency, initiation and longevity of self-harming during adolescence implies different reasons for self-harm. They hypothesise that those who continue to self-harm for a long time may have underlying psychological problems, or chronic stressors, thus differentiating those people from those who harm for a brief period. Ongoing stressors may relate to mental health (Shaffer & Gutstein 2002), stressful living conditions or relationships.

Ongoing influences on a young person's life may also have a positive influence. Social situations eliciting a sense of comfort and well-being may be protective, as reported by Borowsky et al. (2001) from research with a nationally representative adolescent sample in the USA. More specific discussion of ongoing risk and protective factors will be developed in Sections 2.9-2.10.

2.8.2. The role of specific triggers for self-harm

Michel (2000) reported that circumstances around self-harm, often included an acute period of emotional disturbance or distress, distinct from other ongoing or underlying

issues. Self-harm in adolescents may be reactive, triggered by an acutely stressful situation, encounter or experience. This could include interpersonal conflict with parents, peers, boyfriends or girlfriends (Bhugra et al. 2004;Goddard & Higgins 1999;Goddard et al. 1996;Handy et al. 1991;Hawton et al. 1996) or some form of disciplinary crisis such as arrest or anticipated punishment (Beautrais et al. 1996).

There is evidence for and against the role impulsivity in self-harm. In a study of adolescent self-harm, 40% of the young people who had made an attempt reported nothing particular as precipitating events in the days or hours prior to their attempt, however, a further 40% were aware of specific triggers, such as conflict with family or friends, feeling depressed or having problems (Kienhorst et al. 1995). The authors interpret these results as evidence against the impulsive aspect of self-harm. This may be the case, however, it also provides evidence for the heterogeneity of the behaviour, implying impulsive actions at least some of the time, and that the role of short-term triggers is relevant to research on self-harm, but may not provide a complete explanation of the behaviour.

2.9. Social Factors

2.9.1 Ethnicity

This section will firstly define ethnicity as a research variable, and then discuss it in relation to self-harm. As there has been limited research into ethnicity, culture and self-harm specifically in community samples of adolescents, the literature on ethnicity and self-harm in adults and young people who have presented to services has been included in this section of the review. It is also worthy to note that some studies included in this section of the review may be somewhat dated, and relate to communities which are likely to have changed since the research was conducted, such as English studies conducted in the 1980s.

2.9.1.1 Defining ethnicity and use as a research variable

As this doctorate was based in an ethnically diverse part of East London, ethnicity and culture were important factors to consider. They also represent an aspect of self-harm research requiring further exploration in young community samples.

Ethnicity is a socially constructed term referring to a self-assigned group. Ethnic groups share a variety of possible features, including heritage, sense of identity, religion, language, and practices (Bhugra 2004;Mackintosh et al. 1998;Senior & Bhopal 1994). As a person's ethnicity is a fluid and multi-faceted concept, it is open to influence from other groups. A person's ethnicity is contingent on the context, and the combination of other ethnic groups to which any one group is being compared. Sets of values, practices and behaviours differentiate each ethnic group (Hein 1998). For example, groups sharing a common heritage, who practice different religions may be considered different ethnic groups.

Ethnicity is considered as distinct from race, as ethnicity involves the notion of culture, rather than only biological factors. Race refers to physical characteristics such as skin colour and hair texture (Bhugra 2004;Senior & Bhopal 1994). Ethnicity is often used as a euphemism for race (Sheldon & Parker 1992), or as an interchangeable term, despite the fact it is a more complex concept. However, piloting work for RELACHS in East London indicated that adolescents understood "ethnicity or race" to encompass the broader concept of ethnicity (Bhui et al. 2005b). For the purposes of this research, ethnic group names will be capitalised, whether referring to a nationality (such as Pakistani), or racial characteristic (such as Black). Within this review, ethnic groups will be referred to as they were in the studies cited.

2.9.1.2. Assessment of ethnicity

The assessment of ethnicity for research is challenging, as it depends on the groups and factors being compared, and the context of the study (Senior & Bhopal 1994). Self-ascribed ethnicity, akin to that assessed in census data, has been used in recent research (Bhugra et al. 1999b;Cooper et al. 2006). Groups have often been collapsed together for research purposes to have sufficient statistical power for analysis. When the sample size or study design requires researchers to combine smaller ethnic groups for analysis, subtle differences between groups may be overlooked or masked (Senior & Bhopal 1994). For example, in UK hospital-based studies of self injurious behaviour, even where ethnicity has been assessed in the same manner, groups have been referred to as "South Asian", for people of Pakistani, Indian or Bangladeshi origin (Cooper et al. 2006); "South Asian", for people who originated in the Indian subcontinent, or whose grandparents or parents originated there (Bhugra et al. 2004); and "Asian", for people with origins in the Indian subcontinent such as India, Bangladesh, Sri Lanka or Pakistan (Bhugra et al. 1999b).

Merrill and Owens (1986) reported on “Asians”, defined as people of Asian origin born in the UK, or born in India, Pakistan, Bangladesh or East Africa. Handy et al. (1991) referred to “Asians” as people living in the UK, with parents born in the Asian subcontinent. It has also been noted that, at times, the terms “Asian” and “South Asian” are used interchangeably (Bhugra 2004). These slight differences may influence results, or at least raise the question of specificity and generalisability of findings.

Further inconsistency arises from less structured assessments of ethnicity, such as the use of names to ascribe ethnic group (Biswas 1990;McGibben et al. 1992). This has also been applied as a part of a composite assessment, along with religion, first language, place of birth and parental origins in the case that self-ascribed census categories were not available (Bhugra et al. 1999b). The use of names alone for ethnic grouping names is criticised as it may not reliably distinguish ethnic groups. It may have some validity for some South Asian names, however, South Asian Christians may have the same names as white groups, and this might not reliable if people marry into, or change their name to that more ‘typical’ of another ethnic group (Senior & Bhopal 1994).

Research involving ethnicity is valuable as it can inform services about different approaches to illness and illness behaviour. Research considering ethnicity may provide valuable insight into self-harming behaviour in mixed populations such as East London. It is important to acknowledge that the notion of ethnicity is changeable over time, and with the influence of environmental, social or cultural factors (Senior & Bhopal 1994). This may be particularly salient for young people who are likely to be undergoing identity changes as they mature.

2.9.1.3. Rates of self-harm and associations with ethnicity

Adolescent community-based research on self-harm and attempted suicide

At the time of this review, there was limited self-harm research on adolescent community-based samples in the UK. Comparative rates of self-harm by ethnic groups in community studies stem from work in America, or through comparisons of studies conducted in different countries. The results reported here will focus on the ethnic groups to be studied in East London, such as Caucasian, Black and Asian groups. This part of the review will refer to samples recruited through health services and adult studies which have conducted research with the ethnic groups to be included in the empirical research within this thesis.

The community-based research on ethnicity and adolescent self-harm in the UK is mixed. A report by the Office for National Statistics in the UK on young people who try to hurt, harm or kill themselves (Meltzer et al. 2001) showed that the self-reported prevalence in Non-White adolescents aged 11-15 years was greater than in white adolescents (7% and 5.7% respectively). In a school-based cross-sectional study on English adolescents, Hawton et al. (2002) reported a lower rate of self-harm in South Asian females compared with White females (OR 0.55; CI:0.33-0.91), and no significant ethnic differences in males. Thus community based research on self-harm in adolescents in the United Kingdom does not show a consistent pattern relating to ethnicity. This may relate to genuine variation within and between groups, or may be attributed to more methodological issues such as the combinations of ethnic groups studied, how relevant factors were assessed or how the data was analysed.

Adolescent health service-based research on self-harm and attempted suicide

In addition to the mixed results at a community level, results from service-based studies in the UK have shown no significant differences between South Asians and Caucasians in inception rate of adolescent self-harm (Bhugra et al. 2003), presentation to A&E (Merrill & Owens 1986) or in hospital admissions (McGibben et al. 1992). Other studies indicated lower rates presenting to A&E in South Asians compared with whites (Bhugra et al. 2004). Most of these studies had small samples, so the findings should be interpreted with caution.

Research with adults on self-harm and attempted suicide

As there is limited research on self-harm and ethnicity in adolescents, findings with adult samples are briefly summarised. The inconclusive results from the adolescent literature with respect to ethnicity give way to clearer trends in young adulthood. This is demonstrated by service based studies where the rates of self-harm (Cooper et al. 2006) and attempted suicide (Bhugra et al. 1999b) are higher for young South Asian women than White groups in the same age range. In a UK study on hospital presentation for self poisoning, all age comparisons showed that Asian-born females had higher rates of self poisoning than UK-born females and that UK-born males had higher rates than Asian males (Merrill & Owens 1986), although the results for specific age-matched comparisons between ethnic groups were not significant for people under 15 years.

There is some implication that migration could function as a risk factor for young Asian women, or as a protective factor for young Asian men, when compared with a UK-born

sample, Young Asian women also had higher rates of presentation compared with Asian men (Merrill & Owens 1986) and also young Black women (Bhugra et al. 1999b). The EMPIRIC study in England showed that attempted suicide was more frequent in Indian and Pakistani women compared with white British and Irish women (Crawford et al. 2005). These findings imply that the risk for self-injurious behaviour is not necessarily related to belonging in a migrant or "minority group", but may specifically relate to being a migrant from a certain area or culture. These results also imply that further research is required to identify whether increased risk relates to being first, second or a subsequent generation migrant, the process of migration, or aspects of a particular culture or ethnic group within the context of life in a different country, such as England.

Risk factors for self-harm in adults relating to ethnicity

In addition to exploration in prevalence differences by ethnicity, there is a growing body of work addressing risk factors with respect to ethnicity and culture in adults, which will be outlined further in section 2.9.2., after introducing the notion of "culture" in this research.

Research on ethnic density, pertaining to the relative mix of groups within local populations and associated influences on risk factors, has shown mixed results. In ethnic minorities in London, relative rates of adult self-harm in minority ethnic groups varied by area, suggesting risk in some areas and protection in others (Neeleman et al. 2001). A study of self-harm in Manchester reported separate effects for repetition at individual and area levels. Those with a White ethnicity had a higher risk of repeated self-harm, however, at an area level, the risk was significantly higher in wards with a lower proportion of White residents, a risk which did not vary according to individual ethnicity (Johnston et al. 2006). This may imply a role of "relative" minority status, influenced by the differing combinations of groups living in close proximity.

Assessment of ethnicity for research is challenging, and can vary greatly, raising questions about the quality and reliability of the claims stemming from that research. It is feasible that different combinations or definitions of ethnic groups would yield different results, and thus generalising from these studies should be done with caution. The different cultural perspectives on acceptable behaviour and what constitutes normal relationships or responses to stress requires a great amount of sensitivity; to the individual involved in the research and in the assumptions made about the data collected.

2.9.2. Culture and cultural influences on self-harm

This section will define culture and acculturation. As there is limited research on culture in adolescent community-based samples, the review will include adolescent service-based research and key findings from research with adults.

2.9.2.1. Defining culture for research on self-harm

Studies exploring ethnicity refer to issues such as 'cultural conflict' being a risk for self-harm. Culture, like ethnicity, is a highly salient issue in research with mixed populations, and also defined in many ways. It could be conceptualised that if ethnicity refers to the group to which people belong, culture refers to the elements within that group which are shared.

Culture is defined as being the practices, values, and beliefs common to a group of people; guidelines or ways of being as members of a particular group (Helman 2001). This often relates to a shared heritage that shapes their view of the world through family structure, diet, religion, dress, attitudes, languages and types of expression. These influences do however, exist within a social, political, economic and geographical context (Helman 2001). Culture, like ethnicity, is a dynamic and changeable concept (Bhugra 2004). Hein (1998) depicted culture as a repertoire of practices, from which people within that particular group can select and apply to the way they live their lives; allowing for intracultural variation, with the individual identity stemming from these 'guidelines', partly from their own volition, and potentially other influences. For example, following migration by people from a particular ethnic group, there could be different elements of culture drawn upon in their own cultural identity when challenged by coming into contact with others.

2.9.2.2. Acculturation

Acculturation is the process when two or more cultures come in to contact, and the people from different groups are exposed to other ways of viewing and experiencing the world (Berry 1980;Bhugra et al. 1999c;Bhugra 2004). This experience can occur at an individual or group level, and result in possible changes or challenges to cultural identity, thoughts or behaviours (Bhugra 2001). In discussion of Indian communities, Bhugra (2004) notes that cultural practices and identity are maintained for a substantial time post-migration, however, the emphasis on achievement and compliance from young people may become a source of conflict, or acculturative stress. Disagreements about priorities and lifestyle

may lead to a sense of failure, isolation, frustration or to further challenges to values, akin to that reported by young people who self-harm.

Berry (1980) proposed a model of acculturative style which will be applied in this thesis. Berry's framework asserts that people from different ethnic groups could potentially have high or low identification with their own traditional culture or other cultures, often the dominant or host culture. The model is depicted in Figure 2. Strong identification with both their own and the other culture are interpreted as 'integrated' acculturative style. Strong identification with their traditional culture and low identification with other cultures is termed 'separated' or 'traditional' acculturative style. Low identification with traditional culture and high identification with the other culture is seen as 'assimilated', and finally, low identification with both traditional and other cultures is interpreted as being 'marginalised'. Studies applying this model have reported that integrated cultural identity is associated with better mental health outcomes, and that marginalisation is associated with more risk (Berry 1997;Bhui et al. 2005b). The present research will endeavour to explore whether this model of acculturation is supported in relation to self-harm in young people.

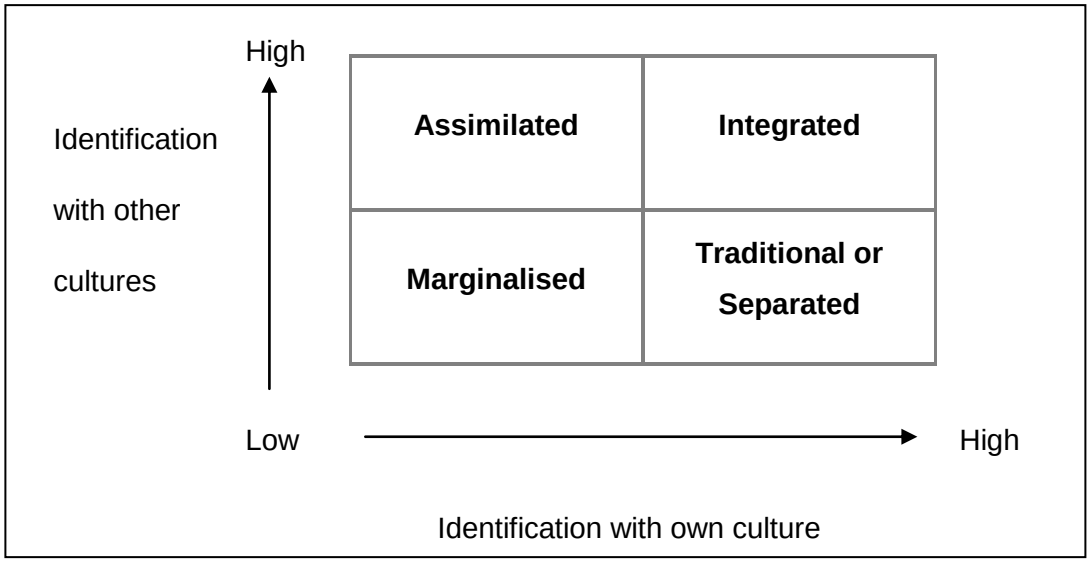

Figure 2: Berry's Model of acculturation after migration

In exploring the role of identity in self-harm, cultural differences may influence how self-harm is perceived. Similarly, behavioural and relationship expectations may have culture-specific variations. For example, in a more collectivist culture where emphasis is placed on identity and inter-dependence, an injury to oneself could function as an injury to the family

or community, as the identity of the individual is as an integrated part of the family and community (Bhugra 2004). This contrasts sharply with the notion of the self in a more egocentric or individualistic society, where independence and a separate self identity are key (Bhugra 2004). Harm by an individual engrossed in such a culture would be more focused on that individual alone, although it would undoubtedly have potential impact of other people around them. Exploration of cultural factors relating to self-harm includes an acknowledgement that there may be culture-specific variation in the impact or understanding of different risk factors between different groups (Bhugra 2004).

Discussion of studies assessing self-harm and the role of culture is difficult, as specific types of cultural variation within and between groups may limit the application and generalisability of the research. Salient issues of conflict for one ethnic group may not be problematic for another. The choice of comparison groups in research may also influence which issues appear important. Specificity is required to strengthen and clarify studies, however, care needs to be taken if attempting to apply or generalise the results to other groups. The research particularly pertaining to culture, cultural conflict and self-harm is somewhat limited, and discussion in the UK tends to focus on specific groups, such as Asian or South Asian women (Bhugra et al. 1999b;Bhugra et al. 1999a;Bhugra et al. 2003;Bhugra et al. 1999c;Bhugra et al. 2004).

Although some believe culture is a weak predictor of suicide (Kosky 2004), there is evidence linking aspects of culture and cultural conflict to self-harm. Attitudes to lifestyle have been shown as a source of conflict for Asian people living in the UK (Bhugra et al. 1999c;Bhugra 2004). The notion of cultural conflict has potential for great variation, and the following discussion relates cultural conflict to self-harm, noting the differences in assessment, and key concepts in this area of research. The assessment of ethnic group increases the complexity of results, so for the following discussion, the ethnic groups used in each study will be presented as they were published.

It is also worth noting that the term ‘culture’ could refer to aspects of lifestyle other than those relating to ethnicity. Although the focus of this thesis will be addressing cultural aspects of ethnic groups, there has also been research illustrating associations between identification with music preference and youth culture such as the reports of high identification with Goth subculture being associated with self-harm and attempted suicide in Scottish adolescents (Young et al. 2006). Other research asserts there is no evidence

for an association between such youth subcultures and self-harming behaviour (Mental Health Foundation 2006).

Adolescent service-based studies

Differences in attitudes and opinions between adolescents and their parents are common irrespective of ethnic group. Comparing differences in attitudes between parents and children among Asian adolescents who presented at A&E following self-harm and Asian adolescents who had not self-harmed, Bhugra et al. (1999c) reported differences in generational attitude towards language, living with a white person, decision making, leisure and food shopping for both 'cases' and 'controls'. Young people tended to express less traditional attitudes compared with their parents. This could be interpreted as illustrating that cultural attitudes do often differ between Asian adolescents and their parents. However, the pattern of parent-child attitudinal disagreement differed by domain. Intergenerational disagreements relating to marriage and work distinguished the young people who had self-harmed from the non-self-harming controls, as no differences were evident for these domains between control parents and children. However, controls did differ from their parents in terms of aspirations, whereas adolescents who had self-harmed did not. These conflicting views relating to marriage, work and aspirations were interpreted as indicating potential risk factors for self-harm.

These results do not clarify why and how attitudinal differences could extend beyond a normal feature of family relationships into extreme distress and self-harm for some people. Is it a function of the degree of difference, or the cultural context in which the disagreement occurs? Or is it mediated by other factors within or between the different parties? Issues relating to identity and independence faced by all adolescents may be exacerbated by the addition of cultural conflict (Bhugra 2004;Handy et al. 1991).

Other service-based studies with adolescents have noted cultural conflict in relation to self-harm. In a small study, Bhugra et al. (2004) noted that Asian adolescents were more likely to report cultural and intergenerational conflict, and also feeling that they were being compared with other people than White adolescents. Biswas (1990) assessed whether dispute over traditional customs or prejudice played some role in self-harm, developing the work by Merrill and Owens (1986) in an A&E based adolescent sample. Self-harm involved culture conflict in 26% of the female Asian sample (n=10), 10% of the Asian males (n=4), and none of the White sample. Although this is an interesting result, questions remains about both the assessment of 'culture conflict' being equally valid for

different ethnic groups, and the potential variation in exposure to different groups having an influence on acculturation processes experienced by these adolescents. This research may also relate to a community that differs substantially from the community to be researcher in this thesis, given that the study is over 20 years old at the time of this review.

In a review of case notes from Asian and Caucasian adolescents in the UK, Handy et al. (1991) reported that disciplinary crises with parents were the most common precipitating factors for both groups. 'Cultural conflict' was defined as occurring when the disagreements involved specific issues relating to traditional, moral or religious expectations differing from Caucasian families, such as style of dress, relationships with children of other racial groups and observance of religious festivals. This was apparent in 17/19 of the disciplinary crises in the Asian sample. It was, however, not possible to use this assessment of cultural conflict for Caucasian adolescents, and thus this study reporting cultural conflict as a precipitating factor for self-harm in Asians was flawed as there was no assessment of the same variable for the Caucasian group.

Family arguments, problems at school and with boy or girlfriends were common precipitating factors for both Black and White adolescents in a case review of presentations after self-harm in South London (Goddard et al. 1996). Black adolescents did, however, report more social stressors, relating to migration and discrimination compared with White adolescents.

Research with adults

The research with adults is somewhat more developed relating to culture conflict. There are consistent findings relating self-harm and cultural conflict in young Asian women, particularly pertaining to conflict with family and attitudes to inter-racial relationships (Bhugra et al. 1999a;Cooper et al. 2006;Merrill & Owens 1986). Merrill and Owens note that rejecting traditional values may result in exclusion at a community and family level, and in the unmarried patients in their sample, both white and Asian people reported family disapproval of relationships. This could indicate that this issue is contentious in numerous ethnic groups, and that conflict over relationships may not necessarily stem from cultural differences. However, Cooper et al. (2006) reported that although young South Asian women (16-24 years) were more likely to self-harm than whites in the same age group, their clinical risk profile indicated lower risk in terms of lower depression, reporting of alcohol or drug use and previous self-harm compared with Whites. This result indicates that there is an impact of cultural factors, particularly interpersonal problems with family,

on self-harm in young Asian women. Alternatively the distress expressed by different groups of people may not reflect the models used in current hospital assessments (Cooper et al. 2006), raising questions about the cultural applicability of risk assessments for self-harm. These studies also imply that cultural conflict may be manifested or reported as interpersonal conflict.

2.9.2.3. Religion

Religious beliefs and practices could be considered an aspect of culture. A review of population-based studies and self-harm (Evans et al. 2004) reported mixed results, with either no association or implied indirect effects of religiosity as a protective factor relating to suicidal phenomena. Borowsky et al. (2001) related a prospective protective influence of religion, with significantly reduced odds for a later suicide attempt in young White males. This result was not found for females or other ethnic groups. McGibben at al. (1992) reported no significant differences in adolescent hospital admissions for self poisoning according to religious group.

2.9.3. Socio-economic status

Adolescent community-based studies present mixed and limited findings relating family socio-economic status (SES) and adolescent self-injurious behaviours. For the purposes of this review, socio-economic status will relate to living conditions and access to material resources. Low SES therefore pertains to low social status, poor housing conditions and limited family income (Schoon 2006). Queries about the role of socio-economic status relate to wider queries about the study of risk and protective factors in general, as there is potential for variation within groups defined together. For example, sharing a similar social class or level of material deprivation does not necessarily equate to uniformity in quality of care or access to resources (Schoon 2006).

Adolescent community-based research

Reviews of adolescent suicidal behaviour in community studies, report limited evidence for associations between SES and suicidal behaviour (Brent 1995;Evans et al. 2004). Lower family SES has been associated with a higher rate of adolescent suicide attempts in community-based research (Fergusson et al. 2000), however, other studies report no association (Brunner et al. 2007;Fortune et al. 2005;McKeown et al. 1998;Sourander et al. 2001;Young et al. 2006).

Socio-economic status has been assessed in a variety of ways in adolescent community-based studies. The use of parental education has particularly mixed results, showing no association with suicide attempts (Sourander et al. 2001); a protective effect if either parent had graduated from secondary school (Haavisto et al. 2005), and also an association with increased odds of suicide attempts if the adolescent's parents had more than a high school education (Hallfors et al. 2004).

The inconclusive results relating to socio-economic status and self-harm in adolescents contrast with the results for adults where there is clear evidence for an association between socio-economic deprivation and self-harm (Gunnell et al. 1995;Hawton et al. 2001a;Platt et al. 1988;Schmidtke et al. 1994). It may be the case that the impact of deprivation on self-harm is not apparent until an older age. In young people SES may be measured indirectly, and other mitigating factors such as education, support services or family involvement may influence relationships identified in research. Alternatively, deprivation may not be acknowledged by the young people directly, and the impact of low socio-economic status may be expressed in terms of other factors such as household structure or stresses within the family. Socio-economic status is difficult to measure in young people, and the interventions of government funding may potentially buffer young people from some impact of deprivation. Further multivariate analyses are required to explore the relationships between indicators of socio-economic deprivation and self-harm in young people.

2.9.4. Family structure

The social environment around young people can have a substantial impact on their health and well-being. One review reported that family structure, including having divorced or separated parents, or living with one parent has been shown to only have an indirect effect on suicidal behaviour in multivariate analyses, if there was any effect at all (Evans et al. 2004). Earlier reviews reported quite contrasting findings, with single parent families being associated with suicidal behaviour (Brent 1995), and divorce or separation by parents having increased risk of youth suicide attempts (Beautrais 2000).

Population based surveys and national statistics on adolescents have shown evidence of relationships between self-injurious behaviours and divorced or separated parents. This evidence stems from research around the world, including England (Hawton et al. 2002;Meltzer et al. 2001), Scotland (Young et al. 2006), and Norway (Ystgaard et al.

2003). In contrast, other population-based research has shown either no effect of parental marital status (McKeown et al. 1998;Sourander et al. 2001), or that self-harm prevalence was relatively lower in adolescents from single parent families (2004).

These results do indicate some evidence that family structure may be related to self-harm in young people, with increased risk for adolescents with divorced or separated parents. However, the results showing limited or no influence of family structure, combined with the possibility that these effects are indirect, possibly encompassing the impact of socio-economic status or interpersonal conflict over family structure per se, raise questions about how family structure influences self-harm. How family structure functions as a risk factor requires further research.

2.9.5. Social support and social connectedness

In addition to the role of family composition, interpersonal relationships and social connectedness are also highly influential. This section will outline previous research on support from family and friends, followed by a section on negative social relations such as bullying.

Firstly, looking at the role of general social support provided through interpersonal relationships, mixed and inconclusive results were reported by Evans et al. (2004) in their review of adolescent population based studies, and a small number of studies addressed the influence of social support on self-harm. Beautrais (2000) noted that although research on protective factors for suicidal behaviour was not as prevalent as research on risk factors, the published findings tended to focus on the buffering effects of social support.

Lack of support and the perception of having nobody to talk to have been associated with self-harm. Stewart et al. (2006) reported that poor interpersonal relationships distinguished suicide attempters from equally depressed controls in a community sample of adolescents. Evans et al. (2005) noted that adolescents who had self-harmed believed they had fewer people to talk to compared with young people without suicidal thoughts or history of self-harm. Not talking about health or mental health problems with anyone increased the odds of attempting suicide in a Swiss nationally representative sample (Rey Gex et al. 1998). It is feasible that young people who have problems may not receive the

support they seek, as their problems or behaviour may deter others from helping them (Evans et al. 2005). There are possible cultural differences in the approach to, and expectations from social support (Kaniasty & Norris 2000). Similarly, there may be cultural variation in the development of interdependent roles within families and communities throughout adolescence (Bhugra 2004).The following sections outline how connectedness or support are associated with suicidal behaviour. This will firstly address family relationships, followed by peer relationships, as different sources of support can have a different impacts on the emotional wellbeing of young people (Klineberg et al. 2006).

2.9.5.1. Family support and connectedness

Good communication and a supportive family lowered the likelihood of suicidal behaviours in young people (Evans et al. 2004). Problems within parent-child relationships may include high or low expectations and control, as well as a limited style of communication (Beautrais 2000). Multivariate analyses showed that unsupportive parents had children with increased risk of suicidal behaviours (Brent 1995;Evans et al. 2004). It was noted that there may be different aspects of family support that are influential for males and for females. For example, in females, family discord was associated with suicidal behaviours in some studies. Family dysfunction and psychopathology have been associated with adolescent attempted suicide. However, this may impact on the child directly, or indirectly, through more environmental influences such as family disruption or lower parental monitoring which also show independent associations (Brent 1995).

Two community-based prospective studies reported on family factors being protective against suicide attempts at follow-up one year later. McKeown et al. (1998) highlighted family connectedness as protective, noting that familial factors could be both environmental and biological. Borowsky et al. (2001) reported on family factors that reduced the odds for attempting suicide 12 months later, with variation by gender and ethnic group. Having a parent present before or after school was protective for White girls, and overall parent and family connectedness reduced odds for later suicide attempts in Black and White Americans. Involvement in family activities was protective for only White males and females (Borowsky et al. 2001).

The majority of results from cross-sectional studies reported associations with self-harm that imply poor family relations as a risk factor. Poor family functioning, such as difficulty planning family activities or not confiding in each other, increased the prevalence of self

reported harm, with 13.6% of those with unhealthy family functioning reporting self-harm, compared with 5% of those with healthy family functioning (Meltzer et al. 2001). Low perceived support from family, and increased conflict with parents showed significant associations with previous suicide attempts in analyses controlled for depression (Lewinsohn et al. 1996). Adjusted analysis showed that not talking with anyone, particularly parents, about health problems, was related to later suicide attempts in Swiss adolescents (Rey Gex et al. 1998). Conflict at home was associated with attempted suicide (Ystgaard et al. 2003).

Together, these population-based studies give some evidence of the role of family dysfunction in self-harm. However, the different constructs assessed, such as 'functioning', 'connectedness' and types of conflict do not illustrate a clear connection with self-harm, nor explain why some people with these problems self-harm, whereas others do not.

2.9.5.2. Friend social support

During adolescence, relationships with peers, boyfriends and girlfriends are central to both identity and gaining independence. Poor relationships with peers have been associated with increased risk of suicidal behaviour in adolescents, however, this was not related to the amount of peer support, and good peer relations did not necessarily reduce risk of self-harm (Evans et al. 2004). Low perceived social support from friends predicted later suicide attempts, but not later depression in a longitudinal population based study of adolescents (Lewinsohn et al. 1996). Connectedness with people at school reduced the odds of later suicide attempts in white, but not black adolescents in a representative population-based sample in the United States (Borowsky et al. 2001).

2.9.6. Bullying

There are surprisingly few reports on bullying in relation to self-harm. Self-harm was more frequent in young people who had been bullied in a community-based study in the UK (Hawton et al. 2002). In a community-based adolescent study in America, being a victim of violence, and also a perpetrator significantly increased odds for attempting suicide in the following year (Borowsky et al. 2001). A school-based adolescent study in Italy showed that direct victimization, such as threats or name-calling both at home and at school had independent relationships with suicidal cognitions or purposeful self-harm (Baldry & Winkel 2003).

2.9.7. Exposure to self-harm or suicidal behaviour

Human behaviour is highly influenced by social interactions and exposure. One aspect of the way interpersonal relationships may influence self-harm is through exposure to suicidal or self-injurious behaviour in others (Williams 1997).

2.9.7.1. Exposure to self-harm or attempted suicide in other people

Exposure to suicidal behaviour can be distressing, and may influence the likelihood of self-harm or attempted suicide in young people. If the suicidal behaviour or self-harm was in a family member or friend, young people may model the behaviour they have seen in others. People exposed to such behaviour may need a means of expressing their own distress felt following that experience. In a school-based study in 13-14 year olds in Dublin, 13.6% of the sample had known someone who had killed themselves, 26% knew someone who had harmed themselves (1998). The study was too small to draw any conclusions about self-harm imitation effects (n=88). In their review of population based studies on suicidal phenomena in adolescents, Evans et al. (2004) report that multivariate analyses repeatedly showed strong associations between suicidal behaviours within the family, and suicidal behaviours in adolescents. Suicidal behaviour in friends showed mixed relationships with self-injurious behaviour in multivariate analyses; however they did have significant univariate associations. The evidence may be mixed due to the relative rarity of completed suicide among family and friends.

Prospective studies predicting later suicide attempts in adolescents report an association between exposure to suicidal behaviour, with some variation by gender and ethnicity. Lewinsohn et al. (1996) reported that recent suicide by a friend was an independent predictor of future suicide attempts, but not a predictor of future depression. Similarly, Fergusson et al. (2003) noted a family history of suicide as a salient factor in predicting later suicide attempts in adolescents, independent of depression. Suicidal behaviour by a family member predicted a suicide attempt in a 12 month follow-up in Black and White males and females. Suicidal behaviour by a friend also predicted later attempted suicide in all groups except for Black boys (Borowsky et al. 2001).

Cross-sectional community-based studies assessing attempted suicide in adolescents reported associations with suicidal behaviour in family member (Rey Gex et al. 1998).

Cross-sectional research from the CASE study indicated that self-harm in friends was significantly associated with self-harm in females (DeLeo & Heller 2004;Hawton et al. 2002;Ystgaard et al. 2003), and males (Hawton et al. 2002;Ystgaard et al. 2003). Self-harm by family members was associated with adolescent self-harm in females (DeLeo & Heller 2004;Hawton et al. 2002) and males (Hawton et al. 2002;Ystgaard et al. 2003). Hawton et al. (2002) noted that although exposure to suicidal behaviour in others was more frequently reported by females; exposure was associated with self-harm in both genders.

2.9.7.2. Exposure to self-harm or attempted suicide in the media

There is ongoing debate about media responsibility for exposure to suicidal behaviours (Beautrais 2000;Stewart et al. 2006), and whether suicide and self-harm in movies such as 'Thirteen', and 'Girl Interrupted' promote self-harm (Ross & Heath 2002). A qualitative study with young people noted that celebrity suicides had been glamorised, and that may have a detrimental impact on youth behaviour (Coggan et al. 1997). There is some hospital-based evidence that exposure to suicidal behaviour on television is associated with an increase in self poisoning, (Hawton et al. 1999b) and also some evidence for a short-term impact on parasuicide (Simkin et al. 1995). However, others have noted a significant association between self-harm and identification with Goth sub-culture, and the implication of copycat effects in harming behaviour emulating that of role models (Young et al. 2006).

Efforts have been made to reduce the amount of detail of suicidal behaviours portrayed in the media, with media guidelines such as those produced by Samaritans (Samaritans 2002) and specific guidelines about reporting suicide from the Press Complaints Commission Code of Practice (Press Complaints Commission 2009). This could, however, be criticised as potentially limiting freedom of speech (Hawton & Williams 2002). Recent commentary about exposure to suicide and self-harm has noted that it is very easy to access information about suicide and suicide methods on the internet (Biddle et al. 2008). The role of the media, including internet and music are ongoing debatable influences on self-harm, with potential to be addressed when exploring this issue in young people.

2.10. Psychological factors

This section will outline evidence relating to self-harm within a broad model of mental illness, or psychological distress. This will be followed by the literature on adolescent self-harm and depression, anxiety and conduct problems.

2.10.1. Mental health and illness

The association between poor mental health and self-harm in young people has been well documented (Apter & Freudenstein 2000;Beautrais 2000;Brent 1995;Evans et al. 2004;Fergusson et al. 2003;Kingsbury et al. 1999;Meltzer et al. 2001;Patton et al. 1997), with any diagnosed psychiatric disorder likely to increase the likelihood of suicidal behaviour, especially in conjunction with other types of risk factor (Apter & Freudenstein 2000;Reinherz et al. 1995). Adolescent research into mental health and self-harm has focused on emotional disorders and depression (Evans et al. 2004). However, there is also evidence for diagnostic heterogeneity among adolescents who hurt themselves (Nock et al. 2006;Reinherz et al. 1995), including disturbed eating (Hawton et al. 2003a;Miller & Taylor 2005), conduct or behavioural disorders (Evans et al. 2004) personality disorders (Horesh et al. 2003;Nock et al. 2006), substance use and abuse (DeLeo & Heller 2004;Garrison et al. 1993;Hawton et al. 2002;Hawton et al. 2006;Miller & Taylor 2005;Nock et al. 2006;Patton et al. 1997;Rey Gex et al. 1998;Rosenberg et al. 2005;Sinclair & Green 2005;Young et al. 2006).

Depressive symptoms, alcohol problems and personality disorders (Linehan et al. 2000) are common associations with suicide attempts, however, as co-morbidity is frequent in mental illness, it is often difficult to pinpoint the specific contribution of the different problems (Apter & Freudenstein 2000). Engaging in self-harm is a common aspect of Borderline Personality Disorder (World Health Organisation 2006), however, this is not often diagnosed in children and adolescents (Nock et al. 2006).

Prospective community-based studies with adolescents report psychiatric morbidity as one of the strongest predictors of later suicidal behaviour (Brent 1995;Reinherz et al. 1995), if not the strongest independent predictor (Patton et al. 1997). In structural equation modelling to predict suicidal behaviour in a longitudinal adolescent community sample, psychopathology had the strongest direct effect on suicidal behaviour, and also an indirect

effect mediated by coping/cognitive style (Lewinsohn et al. 1996). Others report on mental health having a mediating effect; linking increased vulnerability to mental health problems following childhood adversity to later suicidal behaviour (Fergusson et al. 2000).

2.10.2. Depression

There is consistent evidence for a strong relationship between depressive symptoms, affective disorders and self-harm, reported in reviews of adolescent studies (Beautrais 2000;Brent 1995;Evans et al. 2004). Evans et al. (2004) noted that depression was the most frequently reported mental health problem in their review of population based studies, and that it had the strongest association with suicidal behaviours. It is worthy to note that depression and self-harm are both potentially recurrent, and thus relationships over time may vary, depending on how and when those factors were assessed. Research on adolescent depression will be discussed using the terminology reported by each study; that is, relating to self-harm, attempted suicide, or the combination of the two.

Longitudinal community-based research

Prospective relationships between depression and suicide attempts present somewhat varied results, especially relating to the role of current depressive symptoms. That is, past and current depressive symptoms are likely to be related, with previous depression increasing the risk of later depression. Additionally, depression reported in close temporal proximity to self-harm would be expected to illustrate a stronger relationship than depression reported much earlier than self-harm.

In a longitudinal adolescent community study, current depression and a history of affective disorder were strong predictors of future suicide attempts (Lewinsohn et al. 1996). In the West of Scotland Study, young people who had self-harmed or attempted suicide at age 19 had higher depression scores from early adolescence, compared with those who had not self-harmed (Young et al. 2006). Major depression increased the risk of suicide attempts in a cohort study in New Zealand (Fergusson et al. 2003). Depressive symptoms at age eight predicted an increased risk of self-harm ten years later, however, this longitudinal relationship became non-significant when current mental health and social factors were included in analysis (Haavisto et al. 2005). Major depression was not a significant predictor of later suicidal attempts in a model controlling for suicidal behaviour, in a community adolescent sample (McKeown et al. 1998). These results illustrate a

prospective relationship between depression and suicidal behaviours, however, not all depressed people self-harm.

Cross-sectional community-based research

Cross-sectional assessment of depressive symptoms and self-harm have illustrated more consistent findings, possibly relating to the assessment of self-harm and depression at the same time. Community-based cross-sectional studies present significant associations between depressive symptoms and self-harm or attempted suicide (Hallfors et al. 2004;Muehlenkamp & Gutierrez 2004;Ross & Heath 2002). In a cross-sectional adolescent survey in England, Hawton et al. (2002) noted that depression had univariate associations with self-harm in both males and females. This association remained significant for females in adjusted analysis.

Numerous studies present adjusted odds ratios for depressive symptoms predicting self-harm or attempted suicide. In multivariate analysis gauging associations with attempted suicide, the risk of self-harm for those 'often feeling depressed' were 2.3 (95%CI 1.64-3.32) in Swiss adolescents (Rey Gex et al. 1998). In the UK, a national survey exploring adolescents who hurt, harm or kill themselves (Meltzer et al. 2001), the adjusted odds ratios for self reported self-harm were significantly elevated for 11-15 year olds with any depressive disorder (OR 11.96, 95%CI 6.9-20.76) and for any other emotional disorder (OR 3.71, 95%CI 2.28-6.06), compared with young people with no mental disorder.

In terms of prevalence of psychiatric morbidity and self-harm, Meltzer et al. (2001) stated that 37.4% of the adolescents meeting criteria for depression, also reported self-harm; a clear contrast to 4.4% of young people without any mental disorder who also reported self-harm. This result also illustrates that despite self-harm in many depressed young people, the majority of young people who are depressed do not engage in self-harm. This implies that influences other than depression contribute to self-harming behaviour. It has been noted that temporal relations between the assessments of self-harm and the assessment of mental health may vary, so associations in population-based studies may have be an underestimation of the true relationship between mental health and suicidal behaviours depending on how and when these factors were assessed (Evans et al. 2004).

2.10.3. Anger, impulsivity, violence and antisocial behaviour

2.10.3.1. Anger and impulsivity

The role of anger, and different expressions of anger has been raised in relation to self-harm (Ross & Heath 2002). However, the evidence is limited. Being able to express anger may function protectively with respect to suicidal behaviour (Horesh et al. 2003). There may be a stronger relationship between anger and self-harm in young people who have difficulty expressing anger. The role played by anger in self-harm warrants further research.

Impulsivity has repeatedly been linked with self-harm in community research (Garrison et al. 1993;Hawton et al. 2002). Two school-based studies noted that this relationship remained significant for females, but not males in multivariate analyses (Hawton et al. 2002;Ystgaard et al. 2003). Impulsivity appears to have some role in self-harm, however, it may relate primarily to non-depressive suicidal behaviours. Unpacking variation within these behaviours may shed some light on the relationships between anger, impulsivity and adolescent self-harm.

2.10.3.2. Antisocial behaviour

Externalising behaviours, and indicators of antisocial behaviour or conduct problems have been associated with self-harm and attempted suicide (Brent 1995;Nock et al. 2006), particularly in females (Evans et al. 2004). Patton et al. (1997) noted that conduct disorder was associated with self-harm in a community sample of girls, but not boys. Aggressive behaviour was significantly associated with suicide attempts in an adolescent school-based sample in South Carolina (Garrison et al. 1993), however, Apter et al. (1995) noted that aggression was only related to certain aspects, and not all types of suicidal behaviour. Interestingly, conduct disorder showed a protective effect for younger adolescents in studies reviewed by Brent (1995).

Perpetration of violence had significantly increased odds for later suicide attempts in both males and females from Black and White racial groups (Borowsky et al. 2001). Haavisto et al. (2005) reported multivariate associations between aggressive behaviour and acts of self-harm in a community sample of 18 year old males. Violent behaviour has been associated with increased odds for suicide attempts in population studies in the United States (Miller & Taylor 2005). Apter et al. (1995) interpreted a relationship between

aggressive or externalising behaviour and attempted suicides as illustrating two types of adolescent suicidal behaviour; a depressive type and a type related to conduct disorder.

These results indicate some, potentially gender specific, relationship between antisocial or aggressive behaviours, that would be worth exploring further in adolescents, especially as there is evidence for higher rates of conduct disorder in East London adolescents compared with national data in the UK (Stansfeld et al. 2003).

2.10.4. Anxiety

Anxiety has shown univariate associations with suicidal acts in population-based studies, however, the relationship appears to be indirect, as associations were limited in multivariate analyses (Evans et al. 2004). Cross-sectional community-based studies have shown that self-reported anxiety had univariate associations with self-harm in females (Hawton et al. 2002;Ystgaard et al. 2003). Hawton et al. (2002) also reported a univariate association between self-harm and anxiety in males, and a multivariate association in females. In the National Survey on Mental Health of Children and Adolescents in Great Britain, Meltzer et al. (2001) found that 22% of the young people diagnosed with anxiety problems also reported self-harm. Despite limited direct evidence for links between anxiety and self-harm, some authors propose the 'anxiety reduction' model of self-harming behaviour, wherein self mutilation functions to reduce anxiety (Ross & Heath 2002). However, this study also claimed that adolescents who had self mutilated reported greater anxiety than those who had not.

2.11. Concluding comments

The literature review presented information from studies relevant to research on self-harm in minority ethnic groups in a community setting, highlighting areas for potential exploration using both epidemiological and qualitative methods. The review functions as a base upon which the studies in this thesis were built. Chapter 3 presents an introduction to the studies conducted for this thesis, with specific reference to key research which informed the aims, objectives and methodology for each study.

3: Introduction to research project and study design

3.1. Introduction

This chapter presents an outline of the research conducted for this doctoral thesis. The research conducted was set in East London, and area populated by many diverse ethnic groups and communities. This diversity provides the context for unique research on how the psychological and social factors outlined in Chapter 2 may relate to self-harm in young people. The literature review informed both the contents of these studies and the methodologies employed. The issues highlighted in this chapter will be addressed at a population level in a quantitative study (Chapters 4 & 5). The mechanisms within individual experiences of self-harm will be explored in more depth in this ethnically diverse sample in a qualitative study (Chapters 6-8). The data from the two studies provide different insights about this complex topic and the findings will be discussed in Chapter 9.

3.2. Background

Research on self-harm with minority ethnic groups in the UK

There is some evidence from previous research in the UK indicating ethnic differences in adolescent self-harm (Bhugra et al. 2004;Hawton et al. 2002), despite the inception rate being similar for different ethnic groups (Bhugra et al. 2003;Bhugra et al. 2004). Adult hospital-based studies illustrate that there may be different factors leading South Asian women to self-harm compared with White UK people presenting to hospitals. South Asians present with relatively fewer clinical risk factors, such as depression, previous self-harm, drug and alcohol use (Bhugra et al. 1999a;Cooper et al. 2006). Adolescent research has highlighted social stressors experienced by young people from minority ethnic groups (Goddard et al. 1996), and further clarification is required to clarify the role of 'cultural factors' (Roberts et al. 1997) and 'cultural conflict' in self-harm as reported by ethnic minority adolescents (Bhugra et al. 2004;Biswas 1990;Handy et al. 1991). Community based quantitative research is required to assess whether issues evident in young clinical samples (Bhugra 2004;Goddard et al. 1996) are indeed predictive within community samples.

British research has identified a relative increase in the rate of Asian attempted suicide at the age of 18 or 19, following no clear ethnic differences in earlier adolescence (Bhugra 2004). Further research is required to explore whether the differences only emerge with the transition into early adulthood are evident in younger adolescents, and whether social and psychological precipitants of suicidal behaviour and also present at an earlier age. Although there has been some exploration of the role of ethnicity and culture in adolescent self-harm, to the authors knowledge, these issues have not been examined in a longitudinal adolescent community-based study in England. Therefore there is limited predictive evidence for adolescent self-harm in minority ethnic groups.

Justification for prospective quantitative research on adolescent self-harm

Published reviews have noted the need for prospective studies addressing suicidal behaviours in the context of adolescent development and problems (Beautrais 2000;Evans et al. 2004). The majority of research addressing associations with adolescent self-harm has been conducted with cross-sectional studies. Longitudinal research into self-harm would facilitate the analysis of factors which predict self-harm, to be compared with well-evidenced cross-sectional associations.

Two studies report on non-suicidal self-harm (not including attempted suicide) as an outcome in longitudinal research; in South Australia (Martin et al. 2005) and the West of Scotland (Young et al. 2006). The study in Scotland predicted self-harm in older adolescents. To my knowledge, at the time of this study non-suicidal self-harm had not been addressed prospectively with a community adolescent sample in England. This justifies the need to further research, such as that conducted in this thesis.

Prospective studies on attempted suicide in adolescents (Lewinsohn et al. 1996;Reinherz et al. 1995;Wichstrom 2000) have been conducted however, none have specifically addressed the role of culture. Additionally, these studies preclude the notion of self-injury without suicidal ideation. Thus they are restricted to addressing predictors for a sub-set of people who self-harm, namely those actually attempting suicide.

This research will examine salient associations with self-harm, aiming to replicate earlier findings with a multi-ethnic adolescent sample. These analyses will then address specific issues pertinent to minority ethnic groups, including influences such as family and peer relationships, and cultural identity. This focus on cultural factors is aiming to provide a more detailed exploration into components of ethnicity which may explain any emerging

ethnic differences in self-harm, rather than simply identifying categorical differences by ethnicity.

Equivocal and inconclusive associations between self-harm and psychosocial risk factors such as social support, the role of cultural beliefs and practices, family structure and function have been noted in adolescent research (Evans et al. 2004). Evans et al., (2005) claim that longitudinal studies are required to assess the prospective nature of the relationships between family support and self-harm. The role of family in adolescent self-harm will be explored this thesis, with particular interest in the role of ethnicity and culture. Analysis of factors associated with self-harm and increasing understanding about issues faced by East London adolescents from different ethnic groups would be useful to facilitate more specific targeting of interventions and accessibility of services for young people.

Justification for a qualitative study on adolescent self-harm

The mixed results from previous quantitative research provide some insight into this complex behaviour. However, quantitative research is limited by the difficulty accounting for the interpretation of questions by both participants and researchers. Qualitative methods have potential to provide explanations about the phenomena; what it means to different parties.

Qualitative exploration will provide more of an understanding about how young people view these issues in the context of life as an adolescent in East London. For example, how do young people talk abut self harm? And do they acknowledge “cultural factors” in their day to day lives? Qualitative methods would be required to explore how these issues might relate to self-harm, in the experiences of young people. Working with adolescents in East London will provide an opportunity to explore their views about pressures they face, their responses and potential solutions they would propose.

3.3. Mixed methods study design

The empirical research to follow this review will involve a sequential mixed methods approach (Creswell 2003), with a quantitative study followed by a qualitative study. Mixed methods have the capacity to add breadth and depth to understanding within research; addressing different questions and providing different types of data. The quantitative study with a population sample will be aiming to produce findings which can be generalised to

other urban adolescents. The qualitative study addresses the issues of adolescent self-harm at an individual level. It will aim to provide a deeper analysis through a description of how young people see their own self-harm within the context of adolescent life in East London.

3.3.1. Quantitative study

The data for quantitative analysis was collected as a part of the RELACHS (Research with East London Adolescents; Community Health Survey), a longitudinal school-based study, in 2001, 2003 and 2005, which will be referred to as Phase 1, 2 and 3 respectively. This sample is ethnically diverse and stems from an area with high rates of socio-economic deprivation in East London. Questions on self-harm were included in the third phase of this study for this PhD, following a proposal developed by the doctoral student and her supervisors (EK, KB and SS). Analysis of this data will be the first part of the sequential explanatory strategy (Creswell 2003).

Variables in RELACHS were selected for analysis on the basis of previous research; either with the aim of replicating previous findings with a multi-ethnic sample, or to explore aspects of culture and self-harm. Analyses of psychological factors focused on symptoms of common mental disorder, whereas social factors examined related to demographic data, social support, bullying and adverse life events. Hypotheses were developed to explore these areas separately, and a brief justification for each is presented in section 4.3.

In approaching the study of self-harm through analysis of longitudinal quantitative data, some assumptions are made about the role of life experiences and their influences on later functioning. Risk factor models are not deterministic, however, associations can be shown between certain circumstances or events and the likelihood of later self-harm or suicide attempts (Fergusson et al. 2003;Fergusson et al. 2000). McKeown et al. (1998) point out that there is likely to be contribution from proximal risk factors such as recent exposure to suicidal behaviour and also ongoing risk factors such as underlying mental health problems and family factors. They also note that clustering or accumulation of adverse factors in a young person's life may increase the likelihood of self-harm. Other research indicates that current mental health has a stronger association with propensity to self-harm compared with earlier mental health (Lewinsohn et al. 1996). For these reasons, both

cross-sectional and longitudinal analysis of exposures will be used in this study, noting that longitudinal analyses do not necessarily imply causation, but may provide insight into temporal associations between self-harm, risk and protective factors.

3.3.2. Qualitative study

The fourth aim for this thesis was to explore the subjective experience of self-harm and help-seeking in adolescents. Qualitative research with a small sample has the scope to provide explanation of issues and "analytic generalisations" (Curtis et al. 2000), in contrast with the statistical generalisations stemming from population studies using quantitative methods. Qualitative methods also have the scope to explore how people make sense of their experiences and actions within their own social context (Harding & Gantley 1998).

The design for the qualitative study stemmed from questions arising in the literature review; querying how psychological and social factors might function in adolescent self-harm. To give an example, epidemiological research had identified associations between family "functioning", "connectedness" and support, however qualitative methods would be required to explore what that may mean to young people, and the relationship with self-harm.

Previous qualitative research has explore views from adults on cessation of their own harm, from when they were adolescents (Sinclair & Green 2005). This study endeavoured to explore whether similar views were evident during adolescence. A feasibility pilot was conducted (Chapter 6), and this identified further topics to be explored, as outlined in sections 6.5.2. and 7.1. The challenge of talking about self-harm and help-seeking emerged in the pilot, and was incorporated into the design of the qualitative study. This study has scope to question what young people viewed as important aspects of their experiences, exploring the on repeated self-harm and disclosure of self-harm.

3.4. Ethical issues in researching self-harm in young people

Awareness of ethical issues relating to self-harm is pertinent for research in this area. Research participants are required to give informed consent; agreeing to participate having had the objectives the research explained to them (The British Psychological

Society 2006). Informed consent also requires transparent information about who is conducting and funding the research, along with how the information collected will be used (Lewis 2003). Consent is required to be given voluntarily by the participant, without coercion, and with the awareness that it can be withdrawn at any time. Thus informed consent is actually an ongoing process, with participants being able to withdraw from the research or withhold information (Lewis 2003).

Research with young people requires particular care. Issues such as informed consent are debated in adolescent research, balancing the parental duty to protect the child or adolescent's perception of their own responsibility and competence in making their own decisions (Larcher 2005). People under the age of 18 years are legally defined as children (McIntosh et al. 2007), and if participants are under 16 years of age, consent is generally required from their parents or guardians. However in the UK, if a young person is recognised as having the capacity to understand a situation and make their own informed decision, consent is required from the young person rather than that of their parents (McIntosh et al. 2007). In community-based studies on self-harm and suicidal behaviours parents have been informed about the study and given the opportunity to opt their child out. This constitutes passive consent, rather than being required to actively opt their child in to the study (Gould et al. 2005;Hawton et al. 2006).

Some believe that simply asking questions about self-harm may be suggestive, however, research on screening questionnaires in secondary schools in America has indicated that there are no iatrogenic effects of asking adolescents about suicide (Gould et al. 2005). Additionally, care is required about *how* such questions are posed. Patton et al. (1997) proposed that open-ended questions about self-harming methods facilitate research in the area without providing ideas for potentially vulnerable people.

Researchers are required to maintain the confidentiality of information given by participants throughout the research process (The British Psychological Society 2006). Participants should be informed of the ways in which their data will be coded and stored. The identity of participants should be kept confidential in any dissemination of findings.

Consideration is required when researching topics such as self-harm where disclosure may require further intervention. However, knowledge about such a caveat in confidentiality may prevent participants from disclosing personal information such as suicidal ideation or experience of abuse (Langhinrichsen-Rohling et al. 2006). Although

research in contentious areas is required to gain an understanding of behaviours such as self-harm, the welfare of the participants is of the utmost importance. Some studies report referral of participants who were at increased risk of suicide for in-depth mental health assessment (Martin et al. 2005). However, sensitivity is required in order to protect the wishes of the participants, with the aim of reducing the negative consequences of disclosing self-harm (Mental Health Foundation 2006).

The ethical approval obtained for this research will be explained in the procedure section for the quantitative study (section 4.4.3.), the feasibility pilot (section 6.3.3.) and the main qualitative study (section 7.4.).

4: Quantitative study of risk and protective factors for self-harm

4.1. Introduction

This chapter presents the methods employed for the quantitative study, which will be used to address the second and third aims of the thesis. This study comprises the first stage of the sequential mixed methods design (Creswell 2003), presented within the thesis. This quantitative study is a cohort study, set in East London secondary schools which examines associations between social and psychological factors and adolescent self-harm. Cross-sectional and longitudinal regression analyses of self-report data provided by a multi-ethnic community sample will be conducted to address hypotheses stated in section 4.3. The results of these analyses will be presented in Chapter 5.

4.2. Aims:

The quantitative study has three main aims:

i) To estimate the prevalence of self-harm in adolescents in a multi-ethnic community sample.
ii) To ascertain whether relationships between known risk factors and self-harm are replicated in this ethnically diverse adolescent sample.
iii) To explore the associations between self-harm and psychosocial risk factors which have not previously been examined in a young ethnically diverse sample based in the United Kingdom.

Associations to be examined will be divided into four topic areas: (A) demographics, (B) mental health, (C) interpersonal relationships and life events, and (D) cultural identity. Hypotheses will be stated separately following a brief introduction for each section, clarifying the justification for each domain.

In aiming to replicate previous research with this multi-ethnic sample, analyses will examine relationships between self-harm and gender, socio-economic status, psychological distress and depressive symptoms, life events and bullying. Previous

research on interpersonal relationships has shown associations with adolescent self-harm. Within this study, “interpersonal relationships” will refer to a range of relationships. These will include social support from different people, parental style, parental involvement and bullying. Associations will be examined cross-sectionally, assessing the relationship between issues reported in the same phase of the study as self-harm. Where there is sufficient data, the associations will also be explored longitudinally, analysing associations between data from an earlier phase of the study and self-harm reported at age 15-16. Each variable will be examined separately for associations with self-harm, addressing hypotheses presented in the following section.

4.3. Hypotheses:

4.3.1. (A) Prevalence and demographic data

The prevalence of self-harm is predicted to be comparable to the rates reported for the UK sample within the CASE study (Hawton et al. 2006). That study found a lifetime prevalence for self-harm of 16.9% in females, 4.9% in males and the 12 month prevalence of 6.9% for the mixed gender sample (Hawton et al. 2002). Females consistently report more self-harm than males, a trend expected in this East London sample.

The mixed evidence for variation in prevalence of self-harm by ethnicity, particularly in young people implies that other influencing factors may play a role in the prevalence of self-harm across ethnic group. It is possible that clear differences in self-harm by ethnicity become more evident with the transition into adulthood. Thus it is hypothesised that ethnicity will not influence the prevalence of self-harm in this study.

There is mixed evidence about the relationship between socio-economic status and self-harm in young people (Beautrais 2000;Brent 1995;Evans et al. 2004), despite the clearer relationship between socio-economic deprivation and suicidal behaviours in adults (Gunnell et al. 1995;Hawton et al. 2001a). This study is reporting on a consistently deprived sample in which social disadvantage did not demonstrate any association with variation in psychological distress (Stansfeld et al. 2004). For these reasons, it is hypothesised that socio-economic status will not influence the prevalence of self-harm in this sample of adolescents.

In summary, this section will test the following three prevalence and sociodemographic variable hypotheses:

A.1. The lifetime and 12 month prevalence of self-harm in East London adolescents will be similar to other school-based adolescent studies using self-report assessment of deliberate self-harm in the UK.

A.2. The prevalence of self-harm will not vary by ethnicity in this adolescent sample.

A.3. The prevalence of self-harm will not vary by socio-economic status in this sample.

4.3.2. (B) Psychological distress and depressive symptoms

Associations between mental health and self-harm have been shown repeatedly in adolescents. This study aims to replicate previous findings in an ethnically diverse sample, including the finding that although many people who self-harm also display depressive symptoms, the majority of people who are depressed do not self-harm (Meltzer et al. 2001). Both cross-sectional and longitudinal analyses will be conducted on this data, to assess the relative contribution of previous and current mental health. The literature from adult studies does not consistently report associations between depressive symptoms and self-harm in ethnic minority samples, compared with those shown in white UK samples (Bhugra et al. 1999a;Cooper et al. 2006). The current analysis will report the strength of association between mental health and self-harm in adolescence, in a multi-ethnic sample.

The following hypothesis will be tested:

B.1. High levels of current and previous psychological distress and depressive symptoms will be associated with self-harm at age 15-16 years.

4.3.3. (C) Interpersonal relationships and life events

Poor relationships with others, including low levels of social support from family and friends have been associated with self-harm in young people (Borowsky et al. 2001;Brent 1995;Evans et al. 2004;Stewart et al. 2006). Cross-sectional associations have been shown between self-reported bullying and self-harm (Hawton et al. 2002). However, there

are mixed and inconclusive results about the role of relationships between young people who self-harm and the people around them (Evans et al. 2004) and thus these issues require further exploration. These factors relating to relationships will be examined for both longitudinal and cross-sectional relationships with self-harm in this ethnically diverse sample.

The following hypotheses will be tested:

C.1. Participants reporting lower social support will be more likely to self-harm.

C.2. Young people who have been victims of bullying will be more likely to self-harm.

C.3. Participants reporting more adverse life events in the past year will be more likely to self-harm than those who have experienced fewer life events.

4.3.4. (D) Cultural factors and identity

There is limited evidence relating to culture and self-harm for community samples of adolescents in the UK, therefore, the hypothesis in this section is based on research with UK adults and health-service users with different combinations of ethnic groups.

Research on culture could potentially include a wide variety of domains as culture influences many aspects of day-to-day life. Thus there is a need to focus on some specific questions. This analysis will explore culturally salient factors; including assessments of acculturative style developed for this study pertaining to clothing and friendship choices, in accordance with Berry's model (see Figure 2, section 2.9.2.2.).

The following hypothesis will be tested:

D.1. Young people with marginalised and assimilated acculturative styles will have an increased likelihood of self-harm compared with those reporting integrated cultural identity, in accordance with Berry's model of acculturation (Berry 1980).

4.4. Method:

4.4.1. Sample:

The data used for the quantitative analyses were collected for RELACHS (Research with East London Adolescents; Community Health Survey), a longitudinal school-based study. Of the 42 eligible schools in the London boroughs of Newham, Tower Hamlets and Hackney, 30 were randomly selected and invited to participate. Three schools declined the invitation. One of these schools was replaced, leaving a total of 28 schools which participated in the study, including both co-educational and single sex schools (Stansfeld et al. 2003). This sample included Pupil Referral Units in each borough, which had smaller classes of pupils who are unable to attend schools due to illness or exclusion.

There were uniformly high levels of deprivation across the sample, with each ward in the three boroughs being in the bottom quintile on the DETR index for deprivation (Department of Environment Transport and the Regions 2000).

Two representative classes from Year 7 (11-12 years) and Year 9 (13-14 years) from each school were invited to participate in Phase 1 of the study, and to complete self-report questions relating to physical and mental health See Figure 3 for a summary of participation in the entire RELACHS study.

The second phase of RELACHS was conducted in 2003, where the research team followed-up the 2001 sample. Participants who had left their school since 2001 were either visited by a small research team if they were attending a local school; or sent a postal questionnaire if they had moved further away. For follow-up, some participating schools requested that entire classes be surveyed, rather than the participants from Phase 1 only. Additional participants were therefore recruited in Phase 2, making RELACHS an open cohort study.

This process was repeated for Phase 3 data collection with the younger age group only, as the older group had left secondary school in 2003. As one of the participating schools had closed, 27 schools were invited in Phase 3.

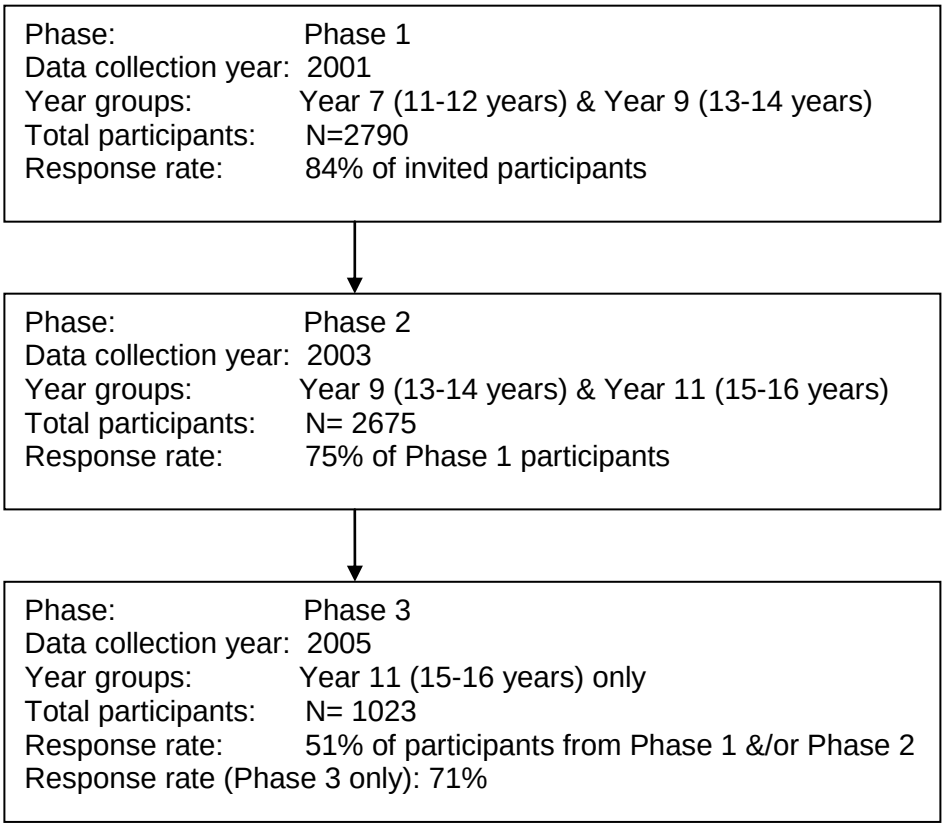

Figure 3: Participation in the RELACHS Study Phases 1-3.

The sample was originally representative of the adolescents attending secondary schools in the three participating boroughs. Attrition analyses will be presented, identifying factors from Phase 1 associated with non-participation at subsequent phases. Analysis addressing the hypotheses will be conducted with data from Phase 2 and Phase 3.

To maximise the data for analysis, separate samples will be defined for the cross-sectional and longitudinal analyses, excluding participants who have missing data for the self-harm variables, as shown in section 5.2.1.1. Exposure variables will be coded to include 'missing' as a category, due to missing data varying for each variable. This will ensure that the total numbers of participants in the sample will stay stable for the analyses.

4.4.2. Measures:

The assessments outlined below comprised a self-report questionnaire. The self-harm categories will be described, followed by exposure variables used in the quantitative

analyses. The questionnaires were designed to include validated age-appropriate questions. Self-harm was included in RELACHS for this doctoral research with assessment questions selected by the doctoral student.

4.4.2.1. Self-harm variables used in regression analyses

Self-harm was assessed using the questions from the CASE study (Child and Adolescent Self-Harm in Europe (Hawton et al. 2002;Hawton et al. 2006;Rodham et al. 2004). See Box 1. This was assessed in Phase 3 of RELACHS only (See Appendix 1 for the full questionnaire, including the questions on self-harm).

Box 1: Questions on self-harm from RELACHS Phase 3

Q36. Have you ever deliberately taken an overdose (e.g. pills or other medication) or tried to harm yourself in some other way (such as cut yourself)? *(Yes, No)*

Q36.1 If you have, when was the last time you took an overdose or tried to harm yourself? (*Less than a month ago, Between a month and a year ago, More than a year ago)*

Q36.2 Describe what you did to yourself on that occasion. Give as much detail as you can. *(Open text box for response)*

This was followed by a list of motives for hurting themselves:

- to show how desperate he/she was feeling
- to die
- to punish him/herself
- to frighten someone
- to get his/her own back on someone
- to get relief from a terrible state of mind
- to find out if someone really loved him/her
- to get some attention
- for another reason, with space to write additional reasons.

The data was cleaned in accordance with the Lifestyle and Coping Skills Survey Guidelines study manual, (Hawton et al. 2006); specific criteria provided by authors). Rodham et al., (2004) note that the criteria used were based on the definition of parasuicide from the WHO/EURO study in adults (Platt et al. 1992).

The CASE study guidelines categorised the responses as either “self-harm” (with sub-categories by method), or as “not self-harm / no self-harm information” (Rodham et al. 2004). The categories for method of self-harm included: self cutting (including scratching or scraping self), hanging / strangulation, suffocation, jumping or throwing self, electrocution, self-battery, alcohol, burning, inhalation/ sniffing, starvation, stopping medication, shooting, drowning, having consumed a non-ingestible object or substance, recreational drugs (opiates / heroin), or having overdosed. To validate the coding, data from this study was coded by the author (EK) and her supervisors (KB, SS, CC) independently, and separate coding was compared to reach a final consensus.

If the description of the harm included use of more than one method concurrently, all methods were coded. However, if it was ambiguous whether the harm was done concurrently, only the first method was coded. If self-harm was described, but a third party had intervened, and the young person had not been able to complete the act they had initiated, it was still coded as having harmed themselves. This interpretation facilitated clarification of what the respondent meant by “self-harm”, and gave the researchers the capacity to define which types of self-harm were included in analysis. This more conservative assessment of self-harm will be referred to as “self-harm (validated)”. The simple yes/no question about having ever harmed will be referred to as “self-harm (Y/N)”.

The timing of the most recent episode of self-harm was assessed, using a closed response question. Participants were asked whether they had self-harmed in the past 3 months, between 3 months and one year, and more than one year ago. Responses to these questions were used to derive a variable assessing the 12 month prevalence of self-harm, based on the self-harm (Y/N) variable. This self-harm category will be used to explore longitudinal relationships between exposure variables and recent self-harm. Prevalence will be presented for the three self-harm categories; lifetime self-harm (Y/N), self-harm (Y/N) in the last 12 months, and lifetime “validated” self-harm. Further regression analyses will only be conducted to assess associations with self-harm in the preceding 12 months, and validated self-harm.

4.4.2.2. Variables used in regression analyses to examine potential risk and protective factors

Variables being tested for associations with self-harm will be referred to as “exposure variables” used in statistical analysis. This term will be used for clarity in describing

statistical associations, acknowledging that associations identified in cross-sectional regression analyses do not imply predictions of future events.

Socio-demographic factors

Ethnicity was assessed in all phases of RELACHS using an adapted version of the Census 2001 question (Office for National Statistics 2001), with additional categories added to reflect the local population, such as categories for Greek, Turkish, Kurdish, Orthodox Jewish, Somali and Vietnamese. In RELACHS, "Asian British" and "Black British" were separate categories to which the young people could assign themselves, rather than parts of section headings, such as 'Black or Black British' as they were used in the Census. Black British was an option for all phases of RELACHS, whereas Asian British was included as an option in Phase 3 only. Self-classified ethnicity is viewed as an acceptable assessment of this fluid concept (Senior & Bhopal 1994). Piloting prior to Phase 1 indicated that the concept of ethnicity was understood by adolescents as 'race or ethnicity', and for this reason, both terms were included in the stem question (Bhui et al. 2005b). Due to small numbers in certain ethnic groups, some have been collapsed to facilitate analysis, for example the 'Black' group consists of people who ticked that they were Black African, Caribbean, British or other. Although some ethnic groups in this analysis are named by nationality (e.g. Pakistani) and other groups refer to skin colours (e.g. Black), all names used to identify separate groups will be capitalised in this thesis.

Length of time living in the United Kingdom was assessed using a closed response question. There were five response options ranging from "less than one year" through to "all of my life" (Office for National Statistics 2001). Length of time spent living in the UK was included as an assessment to complement the ethnicity variable in describing the sample, and also as a potential influence on culture and cultural identity.

Socio-economic status was rated using eligibility for Free School Meals, a composite assessment of socio-economic status, supplied by the Local Education Authority in each borough. Parental employment was assessed separately for each parent/carer living with the participant, with a question adapted from the West of Scotland Study (West & Sweeting 1996). To accommodate the variation in family composition, including single parent families, the parental employment data has been collapsed to assess young people having either neither parent employed or at least one parent employed.

Household composition and family structure were assessed using questions adapted from other adolescent studies (Health Education Authority 1997;Rogers et al. 1998;West & Sweeting 1996). Participants were asked to write the number of people they live with, given closed options questions about whether they lived with their parents, step-parents, or were in care. The number of rooms was also assessed, and used to calculate overcrowding. A household was considered overcrowded if there were more than 1.5 people in the residence per room, in the house, excluding the kitchen, bathroom and hallway (Office for National Statistics 2001).

Psychological distress and depressive symptoms

Psychological distress was assessed using the child self-report version of the Strengths and Difficulties Questionnaire (SDQ), (Goodman 1997;Goodman et al. 1998), a validated 25 item questionnaire for young people aged 4-16 years. This had previously been used in epidemiological studies such as the Health of Young People in England (HYPE) study (Prescott-Clarke & Primatesta 1998) and the Mental Health of Children and Adolescents in Great Britain Study (Meltzer et al. 2000). The SDQ has also been validated in other ethnic and cultural groups, for example adolescents living in Bangladesh (Mullick & Goodman 2001), implying validity for use in a sample of East London Bangladeshi adolescents.

The SDQ contains five subscales pertaining to emotional symptoms, hyperactivity, peer problems, conduct problems and prosocial behaviour over the past six months. Each item is rated as “Not True”, “Somewhat True”, or “Certainly True”, and scored 0, 1 or 2 with higher scores indicating more difficulties or extreme behaviour. The total score is derived by summing all subscales except for prosocial behaviour, producing a total score ranging from 0-40. If one or two items were missing, item scores were imputed, based on a mean score of responses to other SDQ items. Thresholds have been used in this analysis, identifying caseness as a categorical exposure, rather than using the total score as a continuous variable. This will facilitate examination of those indicating “borderline” or “case” ratings of psychological distress in relation to self-harm, paying particular attention to participants reporting higher level of psychological distress. The scale will not be used as a continuous exposure as incremental differences across the whole scale may be difficult to interpret in a clinically meaningful way. Separate analyses were conducted for the emotional symptoms and conduct problems sub-scales to explore the associations between different aspects of psychological distress and self-harm.

Information on the official SDQ website categorise a score of 0-15 as normal, 16-19 as borderline and 20-40 as abnormal or "cases". These are roughly set to identify the highest scoring 10% as cases and then next 10% as borderline in community samples *(http://www.sdqinfo.com/ScoreSheets/e2.pd, accessed 020908)*, however, it is noted that these thresholds may require adjustments to suit specific populations.

In this present study, scores of 18 or above were considered to indicate psychological distress in the young person (Stansfeld et al. 2004), referred to in this thesis as being a "case", or as reporting "psychological distress". A nationally representative sample of British adolescents was the source of the caseness threshold, as approximately 10% of the community sample scored within that range (Meltzer et al. 2000). The threshold established for this United Kingdom adolescent sample is lower than that on the SDQ website. It was deemed more appropriate for the present analysis to use cut-offs from a UK adolescent sample, rather than the general SDQ caseness threshold. The influence of different thresholds was checked by repeating analyses using the thresholds from the official website recommendation cut-offs.

Depressive symptoms were assessed using the Short Moods and Feelings Questionnaire (SMFQ), (Angold et al. 1995;Messer et al. 1995). This is a thirteen item self-report scale, assessing core depressive symptoms in children and adolescents over the previous two weeks. Each item is rated as "True", "Sometimes" or "Not True", scoring 2, 1 or 0 points respectively. The scores are summed and a total above 8 was defined as indicating a 'caseness', or having depressive symptoms. The SMFQ has been reported as providing a reliable measure of adolescent depressive symptoms, appropriate for use in epidemiological surveys (Messer et al. 1995). This measure was included as it provides a more comprehensive assessment of depressive symptoms than the SDQ.

Composite variables were derived to examine longitudinal associations for each of the mental health exposures separately (SDQ total, SDQ emotional symptoms, SDQ conduct problems and SMFQ). These variables grouped participants as having never been cases, cases at Phase 2 only, Phase 3 only, or at both Phases. If participants had been a case at one phase and had missing data for the other, they were coded as having been a case at that single phase in that composite variable. This is justified by the other cross-sectional analysis including all cases from that phase, irrespective of missing data at the other phase. If participants were not cases and had missing data for the other phase, they were counted as having missing data.

Interpersonal relationships and life events

Social support was assessed in the three phases of RELACHS using the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al. 1988). This scale contained 12 items pertaining to perceived support from friends, family and a special person. Each item is rated on a 7 point likert scale with responses ranging between “Disagree Very Strongly”, and “Agree Very Strongly”. Scores were summed to produce a rating of social support for each subscale; support from friends, family or a special person. Combining these sub-scales produces an assessment of total perceived social support. The MSPSS has demonstrated good construct and discriminant validity (Zimet et al. 1988). The total scale and each of the subscales were divided into tertiles for this analysis to compare high, medium and low perceived social support.

A composite variable was derived for examination of longitudinal associations; combining high and moderate support to compare with low support across Phases 2 and 3. The group containing both high and moderate support will be referred to as “higher support”. The four categories for this analysis were: (i) higher support at both Phases 2 and 3, (ii) higher support at Phase 2, with low support at Phase 3, (iii) low support at Phase 2 with higher support at Phase 3, and finally (iv) low support at both Phases 2 and 3. If data was missing at either time, this variable was coded as missing.

Parental involvement in school activities was assessed by two questions in Phase 2 and Phase 3. Pupils were asked whether parents were willing to help with problems at school and give their child encouragement to do well at school. The questions were scored on a five-point scale ranging from “Always” to “Never” (Health Education Authority 1997). The scores for the two items were summed. As the data were skewed towards greater support, a median split was used to establish two categories; high parental involvement (“always” for both questions) or low parental involvement.

Parental style was assessed in Phase 3 only using questions adapted from the Whitehall II study. Questions were asked separately for the male and female carers who looked after the participant when he/she was growing up. Participants were asked to rate parent/carer understanding, love and affection shown, strictness of rules, harshness of punishment and availability to talk in each of their parents/carers. The four questions on understanding, love, time to talk and affection were summed and reliability was assessed using Cronbach’s alpha. The warmth questions showed very strong internal consistency for

female carers (α = 0.998) and male carers (α = 0.998). This will be analysed as an overall assessment of parental warmth assessment, split into tertiles to enable a comparison of high, medium and low parental warmth. The questions on strictness and harshness were summed as an assessment of strictness, and the two items showed good internal consistency for female carers (α = 0.997) and male carers (α = 0.996). This assessment of parental strictness was also spilt into tertiles for analysis (Stansfeld et al. 2008).

Lifetime experience of bullying was assessed in all phases with the question: have you ever been bullied at school? In Phase 2 there were also questions on being victimised due to race or religion, the way you look or talk, had rumours or lies spread about you or having been hit, slapped or pushed (Health Education Authority 1997). The lifetime measure takes account of different types of bullying, combining responses from the five questions.

Adverse life events were assessed in Phase 3 using an eight item scale of questions from the Whitehall II Study phase 5 questionnaire adapted to be age-appropriate for the RELACHS sample. Five of those questions had been selected from the EPIC Health and Life Experiences questionnaire (Wainwright & Surtees 2002). The aim of these questions was to assess different aspects of emotional and material deprivation during adolescence. Participants were asked to tick “yes” or “no” for lifetime exposure to frequent parental arguing, being in care, their family having continuous financial problems, family bereavement, serious illness or injury in their immediate family, parental divorce or separation, someone in their family experiencing a mugging or burglary, and parental alcohol consumption had caused family problems. For the purposes of these analyses, exposure to adverse life events were summed to derive a total life events score, which was categorised as no reported life events, 1, 2 and 3 or more adverse events. Assessments of life events vary in severity and the impact on each individual, and this is difficult to control for in survey-based data collection, however, an attempt to reduce recall bias was used, requesting participants answer questions about events in the past year (Williams & Uchiyama 1989). Reliability analysis was conducted on the eight items to be tallied for the total life events score. The Cronbach’s alpha was 0.94, showing high average inter-item correlation. The alpha was predicted to reduce if any of the eight items were deleted.

Cultural identity

Cultural identity was assessed using the Cultural Identity Schedule (CIS) developed and validated for this study (Bhui et al. 2005a;Bhui et al. 2005b) based around Berry's typology of acculturation styles (Berry 1980). The CIS assesses the domains of clothing and friendship choices. Participants were asked to rate whether their choices were similar to their own or other ethnic groups. To incorporate the influence of context, clothing choices were assessed at home with family and outside school with friends. Friendship choices were assessed in the context of school or outside of school. The scores for identification with participants' own or other ethnic groups were combined in accordance with Berry's two-dimensional model of acculturation, comprising of four groups of acculturative style. High identification with both own and other ethnic groups was termed "integrated", high identification with one's own ethnic group, and low identification with other ethnic groups was referred to as "traditional". High identification with other ethnic groups combined with low identification with one's own ethnic group was termed "assimilated", and low identification with both own and other ethnic groups was labelled "marginalised", in terms of cultural identity.

The RELACHS study also collected data on physical health, substance use, diet and dental health which will not be included in the current analysis.

4.4.3. Procedure:

Each phase of the RELACHS study was granted ethical approval from the local East London and City Research Ethics Committee. Data collection was conducted with the assistance of Local Education Authorities in Newham, Tower Hamlets and Hackney and the participating secondary schools.

The same methodology was used for each phase of the study, as outlined in the RELACHS Phase 1 study report (Stansfeld et al. 2003). Schools were informed about the study and the Head Teachers were invited to provide consent on behalf of their schools to participate in the study and to provide assistance in approaching pupils to participate. Each pupil was assigned an alphanumeric code to link their responses throughout the longitudinal study. Teachers, participants and their parents were given information about the study one week prior to the assessments (Appendices 2-4). Parents had the opportunity to opt their child out of the study at each phase; thus giving passive consent. In order to account for the ethnic diversity within the sample, parent information and opt-out

forms were translated into Bengali, Gujerati, Punjabi and Urdu. Participants signed to give active consent after receiving further verbal information and being given the opportunity to ask questions about the study on the day of assessment (see Appendix 5). The questionnaires were administered in class groups at each school, supervised by 3-4 researchers. All participants were debriefed following completion of their questionnaire and provided with written information about local health services for young people.

As noted in Chapter 1, the doctoral student assisted with questionnaire development, organising and conducting the data collection for the RELACHS study in Phases 2 and 3. She was involved in database organisation and data cleaning. All data analysis for this thesis was conducted by the doctoral student.

4.4.4. Analysis:

Analysis was conducted using SPSS (Version 13). An epidemiological risk factor approach has been adopted for analysis (Bhopal 2002) as used in longitudinal research on this topic (Fergusson et al. 2000). Logistic regression has been used in the analysis addressing the hypotheses for this study, as the models are examining associations with a binary variable; the presence or absence of self-harm (Field 2000b). Logistic regression facilitates an estimation of the change in the odds of the "presence of self-harm", for a unit change in each "exposure variable" entered into the model. Models will be conducted to examine associations with lifetime self-harm (validated) and self-harm (Y/N) in the past 12 months.

4.4.4.1. Descriptive analysis:

Initial descriptive analyses were conducted on all variables to ascertain the prevalence of exposures and self-harm categories. These descriptives function to contextualise the study, and highlight unique characteristics of the sample. Information about the method, timing and motivation for self-harm reported by participants will be presented in the results section.

Unadjusted regression analyses were used to examine associations between exposures and two self-harm categories; self-harm (validated) and self-harm (12 months). Significant associations were explored further in multivariate models adjusted for potential confounding factors to assess whether variables had direct, independent associations with self-harm. Further multivariate models were developed using the validated measure of

self-harm as that was the most conservative assessment. However, as that measure indicated lifetime self-harm, the multivariate models will also be conducted using the 12 month self-harm category, as it also has the scope to examine longitudinal relationships with self-harm. Regression analyses were not conducted if the reference group contained less than five participants.

As self-harm has been shown as more prevalent in females, all exposure variables were examined for an interaction with gender. If the overall interaction was significant ($p<0.05$), further analyses for that variable would be stratified by gender, as that may indicate different trajectories or relationships between factors for males and females. Testing for interactions was conducted twice; with and without the missing data included as an exposure category.

4.4.4.2. Weighting

Weights were calculated for each phase to account for unequal probabilities in selection, to be representative for the adolescents attending secondary schools in the area. Prevalence estimates for self-harm will be checked with weighted data to ensure the estimates are meaningful representations for the three participating boroughs.

4.4.4.3. Power calculation for associations with self-harm

In order to estimate the precision in detection of associations with self-harm in this study, a power calculation was conducted, informed by previous research, looking at the power of detecting an association between the presence of any mental disorder and self-harm. This was done despite the analysis for this thesis being conducted on a study which had been designed by the RELACHS steering committee five years earlier. For this power calculation, the prevalence of self-harm was estimated to be 7%, in agreement with those reported by Hawton et al., (Hawton et al. 2002). It was known that there were 1023 participants in RELACHS Phase 3, the study analysed in this thesis. In a sample this size, the 95% confidence interval for 7% prevalence would be 5%-9%. The National Survey of Children and Adolescents in Great Britain reported a prevalence of 11.2% for any mental disorder in people aged 11-15 years (Meltzer et al. 2000). Therefore, with a sample that size, and the above estimate of prevalence of self-harm, analysis would detect an association with 80% power (at the 5% significance level) if the prevalence of any mental disorder was 24% or more among those who self-harmed.

To give another example, the prevalence of emotional problems in 11-15 year olds, being 5.6% (Meltzer et al, 2000) will be used. In order to identify an association between emotional problems and self-harm in a sample of 1023 people, (where the self-harm prevalence was estimated at 7%), analysis would have 80% power (and 5% significance) to detect any associated factors with a prevalence of, for example, 17% in the people who self-harmed and 6% in the people who had not self-harmed. Therefore if the prevalence of emotional disorders was at least 17% in people who self-harmed, the following analysis would have an 80% chance of finding an association with $p<0.05$.

Given that the analysis relating to the presence or absence of self-harm was secondary analysis of a pre-established database, such power calculations have limited influence on the analysis conducted. With a sample that size, there may be limited scope for stratification by factors such as ethnic group or gender, as stratification would reduce statistical power. It is, however, important to examine the statistical power when conducting secondary analysis as it assists in clarifying whether a lack of association indicates that no associations exist, or simply that the data being examined was not powered to identify the effect.

4.4.4.4. Multivariate model development

Associations in univariate regression models which showed a significance level of $p<0.05$ were included in more complex models. Adjusted analysis was conducted examining associations with the validated assessment of self-harm, and where there were sufficient numbers, the 12 month prevalence variable was used. Variables were entered into separate regression models on a theoretical basis, that is, not using stepwise entry into models (Field 2000b). Models will be built to explore the potential confounders within the relationships between exposures and self-harm.

All adjusted models will include gender, ethnicity and eligibility for free school meals, as a proxy for socio-economic status (SES). These will be included as a conservative approach to the analysis, irrespective of whether these factors have a significant relationships with self-harm. For example, although the sample is ethnically diverse, and there is limited variation in self-harm by ethnic group, adjustment for ethnicity is aiming to account for any dominance of any particular ethnic group within the sample which may influence other associations but not be significant due to limitations in statistical power. Similarly socio-

economic status will be included to factor out any influence that SES may have on the relationship between the exposures and self-harm variables.

Consideration of adjusting for multiple comparisons

Given that multiple regression models were to be conducted in this analysis, consideration was given to applying Bonferroni adjustments. Although this is a debatable issue within epidemiological research (Altman 2000), it was decided not to make any adjustment for the separate statistical tests in this analysis. It is also noteworthy that as confidence intervals will presented with p-values and the numbers of tests are evident in the results, emphasis did not only rest on p-values; rather with the overall pattern of results. Where there was a significant result, this was only noted if the association was strong, taking into account the number of tests, rather than applying further manipulation of the data.

5. Quantitative study results

5.1. Introduction

This chapter presents the results from statistical analysis of the RELACHS data, using the methodology outlined in Chapter 4. The main results within this chapter have been divided into four sections (5.2-5.5), and analyses address the hypotheses stated in section 4.3. Section 5.2 reports on sample characteristics, sample attrition, missing data and the prevalence of self-harm. The first section also addresses hypotheses relating to demographic factors. The following section (5.3) reports analyses of self-harm and psychological distress assessed in RELACHS. The third results section deals with relationships between self-harm and interpersonal relationships, including social support, and bullying. Associations between self-harm and adverse life events have also been analysed and reported in this section. Section 5.4. addresses cultural factors, presenting the analysis of assessments of acculturation and self-harm in these East London adolescents. Univariate regression analyses have been conducted to assess relationships between self-harm and risk and protective factors. Further analyses included adjustment for potential socio-demographic confounders (gender, ethnicity and eligibility for free school meals as a proxy for SES).

Section 5.6 presents a summary of the quantitative analyses. These analyses will also inform the development of the pilot and main qualitative study presented in Chapters 5-8.

5.2. Sample characteristics, attrition and prevalence of self-harm

5.2.1. Sample characteristics

This section will present a description of the quantitative dataset to be used for analysis. It also includes a description of the self-harm reported by participants and the self-harm variables used for regression analyses. This section will also present results showing relationships between self-harm and key demographic characteristics. Both longitudinal and cross-sectional analyses will be used to describe the dataset and self-harm variables.

The demographic characteristics of the participants who have self-harmed will be presented from cross-sectional analyses only, using data from Phase 3 of RELACHS.

Phase 3 of RELACHS had 1023 participants. The longitudinal participation status of the Phase 3 participants is shown in Table 2. Analysis addressing attrition uses data from Phase 1 to examine participation in Phase 3. 74.6% of Phase 3 participants had also participated in Phase 1. Figure 4 indicates the participation in Phases 1 and 2 of RELACHS leading to participation in Phase 3.

Table 2: Longitudinal participation status of Phase 3 participants

Longitudinal participation status	**Participated in RELACHS Phase 3**	
	N	**%**
Participated in Phases 1, 2 & 3	702	68.8
Participated in Phase 1 and 3, not Phase 2	62	5.8
Participated in Phase 2 and 3, not Phase 1	79	7.8
New participant in Phase 2 & participated in Phase 3	95	9.4
Participated in Phase 3, and not phase 1 or 2∂	34	3.2
New in Phase 3∂	51	5.0
Total	1023	100

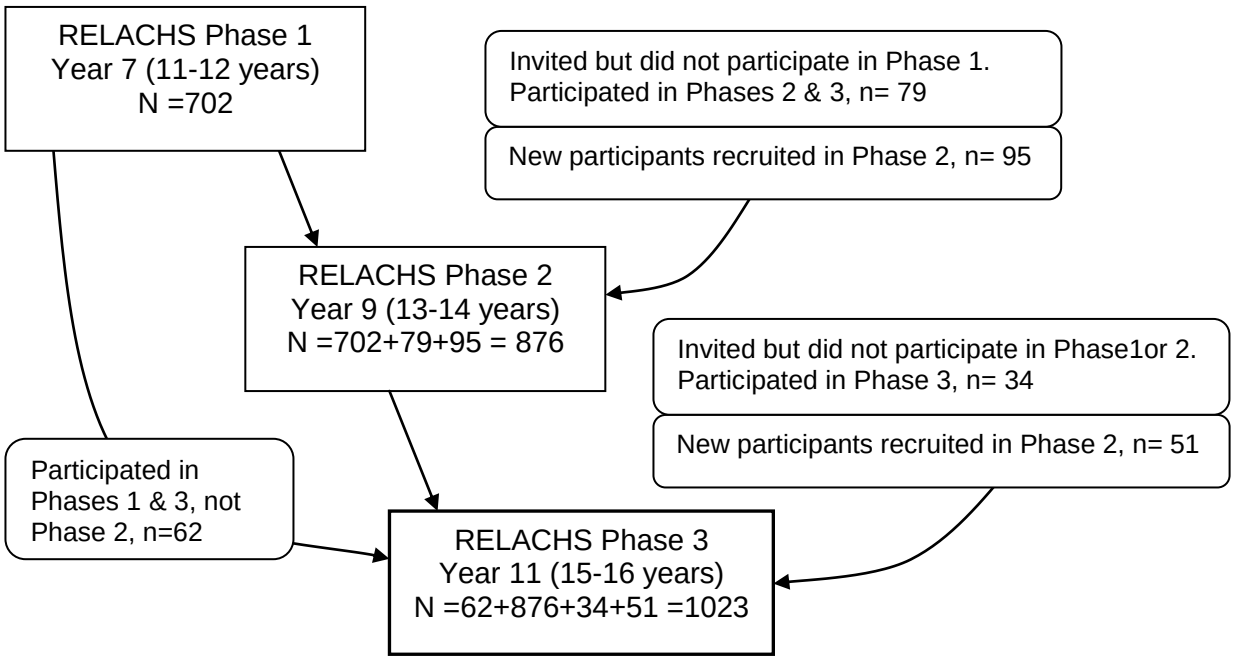

Figure 4: Number of participants in RELACHS Phases 1-3

To assess the loss to follow-up, univariate logistic regression analyses were conducted using variables from Phase 1, to examine associations with participation in Phase 3. This analysis showed that participants who were cases on the SDQ in Phase 1 were less likely to participate in Phase 3 than those who were borderline or not cases (OR 0.59, 95%CI 0.41-0.83). Participants who had ever been bullied at Phase 1 were less likely to participate (OR 0.69, 95% CI 0.55-0.86) compared with those who had never been bullied. Participation was not associated with socio-economic indicators including parental employment status, eligibility for free school meals or living in an overcrowded home (> 1.5 people per room). Neither depressive symptoms (SMFQ caseness) nor social support in Phase 1 was associated with participation in Phase 3. Girls were more likely to participate in Phase 3 than boys (OR 1.33, 95% CI 1.07-1.64).

Regarding ethnicity, people of South Asian origin were more likely to participate compared with White-UK participants (Bangladeshi OR 2.26, 95%CI 1.55-3.00; Pakistani OR 2.26, 95% CI 1.39-3.66; Asian Indian OR 3.04, 95% CI 1.85-4.97). In Phase 3, a category of "Asian British" was added as an option for self-report ethnic group. Two thirds of the Phase 3 "Asian British" participants had categorised themselves as Bangladeshi in Phases 1 and 2. The remaining people who were Asian British in Phase 3 were categorised as Asian Indian, Pakistani, mixed race or other ethnicity in earlier phases.

5.2.1.1. Missing data on the self-harm variables

Eighty four participants had missing data on the self-harm (Y/N) variable. These participants were excluded from further analyses. This group was examined to ascertain if it showed any distinctive characteristics. Univariate regression analysis was used with Phase 3 variables to examine associations with missing data for the question on self-harm.

Missing data for self-harm was associated with male gender (OR 1.69, 95%CI 1.07-2.66), living in an overcrowded home (OR 2.24, 95%CI 1.28-3.93) and eligibility for free school meals (OR 2.04; 95%CI 1.26-3.29). Three ethnic groups had increased odds for missing data on this question compared with the White-UK group. These groups were Bangladeshi (OR 3.37, 95%CI 1.35-8.43), Asian Indian (OR 3.75, 95%CI 1.29-10.94) and Black (OR 3.99; 95%CI 1.61-9.86). Missing data for the self-harm question was not associated with parental employment, psychological distress, depressive symptoms, social support or experience of bullying. These associations show that the attrition was not random, however, it is difficult to interpret the direction of the effects. Nonetheless, it is feasible that

results may be conservative estimates as some participants from higher risk groups are not in the final analyses.

5.2.1.2. Samples used in further analyses and approach to missing data

In order to maximise the power of analyses using the data available, missing data for exposure variables were included in all logistic regression. Missing data on exposure variables was coded as a category and included in analyses. This was not done to examine effect size or associations with missing data, but rather to limit the variation in the sample between analyses. Conducting complete case analysis was considered, however, as missing data varied between exposure variables, the sample size was greatly reduced. For example, more than 350 participants had missing data on Phase 2 social support variables. The results for missing data will be included in results tables. Table 3 presents the samples to be used in further analysis, accounting for missing data on the self-harm variables.

Table 3: Samples to be used in cross-sectional and longitudinal analyses

	Lifetime self-harm (validated)	*12 month prevalence of self-harm*
Cross-sectional [∂]	*905*	*939*
Longitudinal	*N/A*	*807*

[∂] The cross-sectional sample sizes differed by the 34 people who had not given further information to validate their response to the binary question on self-harm. The longitudinal and cross-sectional samples differed due to participants either not participating in Phase 2, or being new to the sample in Phase 3.

The prevalence will be presented for four "categories" of self-harm in Table 5, with discussion of hypothesis A1. The four categories are: the lifetime binary (Y/N) self-harm, self-harm in the past 12 months for this binary (Y/N) assessment, lifetime self-harm (validated), and self-harm in the past 12 months for the validated assessment, where further information about self-harm met the study criteria, outlined in section 4.4.2.1.

Further analyses will only present findings for lifetime self-harm (validated) and self-harm (Y/N) in the preceding 12 months. Longitudinal analyses will only examine relationships between Phase 2 variables and self-harm in the 12 months preceding Phase 3.

5.2.1.3. Phase 3 sample

Table 4 presents descriptive data for demographic and socio-economic factors reported by the participants of RELACHS Phase 3. The Phase 3 sample included young people from a variety of ethnic groups. The self-report categories from the RELACHS questionnaire have been collapsed to show the main ethnic groups in the sample. The largest ethnic groups

were White (White-UK or White other), Bangladeshi and Black. Due to limited numbers within ethnic groups, the group which will be referred as 'Black' is a cluster of ethnic groups, constituted of participants who described themselves as Black African (n=104), Caribbean (n=49), British (n=38) or 'Black other' (n=7).

Table 4: Socio-demographic characteristics of RELACHS Phase 3 participants.

Socio-demographic characteristics		**RELACHS Phase 3 participants**	
Variable	**Variable Categories**	**N**	**%‡**
Gender	Female	502	53.5
	Male	437	46.5
Ethnic group	White	237	25.2
	Bangladeshi	202	21.5
	Black	199	21.2
	Asian Indian	68	7.2
	Pakistani	70	7.5
	Asian British	60	6.4
	Other	103	11.0
Parental employment	Neither parent employed	298	31.7
	At least one parent employed	563	60.0
	Missing	*78*	*8.3*
Eligibility for free school meals	Eligible for free school meals	450	47.9
	Not eligible for free school meals	458	48.8
	Missing	*31*	*3.3*
Household composition	Lives with two parents	557	59.3
	Lives with one parent only	166	17.7
	Lives with neither mother nor father	10	1.1
	Missing	*206*	*21.9*
Household overcrowding (>1.5 people per room)	Overcrowded home	270	28.8
	Home not overcrowded	604	64.3
	Missing	*65*	*6.9*
Length of time lived in the UK	All of participant's life	740	78.8
	Over 10 years	85	9.1
	6-10 years	43	4.6
	Less than 5 years	67	7.1
	Missing	*4*	*0.4*
Total		**939**	**100**

‡Percentages are given by column, for each variable.

5.2.2. Hypothesis A1: Prevalence

The lifetime and 12 month prevalence of self-harm in East London adolescents will be similar to other school-based adolescent studies using self-report assessment of deliberate self-harm in the UK.

5.2.2.1. Cross-sectional analyses (Phase 3)

The information used to derive the self-harm (validated) category included details about the timing, methods and motivations for participants' most recent episode of self-harm. This descriptive information will be reported after the prevalence, and followed by analysis addressing demographic data and self-harm.

Thirteen percent (n=122) of the 939 Phase 3 participants had ever self-harmed, and this will be referred to as self-harm (Y/N). 120 people responded affirmatively to the binary question about ever having self-harmed. A further two participants provided a method describing their self-harm but had not ticked the Y/N question. These participants were recoded to be included as having self-harmed. Table 5 presents the prevalence of self-harm in this sample. Self-harm was more prevalent in females than males, with 19.5% of females reporting having ever self-harmed compared with 5.5% of the males. Of the 122 people who had self-harmed, 121 indicated the timing of their most recent episode. Sixty eight (7.3%) participants had self-harmed in the past year, and this assessment was used for further analysis. Twenty seven of those who had self-harmed had done so in the past month.

Table 5: Prevalence of self-harm by gender

	Whole sample		***Females***		***Males***	
Assessments of self-harm	***n***	***% (/939)***	***n***	***% (/502)***	***n***	***% (/437)***
Self-harm (Y/N)	*122*	*13%*	*98*	*19.5%*	*24*	*5.5%*
Self-harm (Validated)[∂]	*88*	*9.4%*	*74*	*14.7%*	*14*	*3.2%*
Self-harm (Y/N) in the past 12 months[∂]	*68*	*7.3%*	*53*	*10.6%*	*15*	*3.4%*
Validated self-harm in the past 12 months	*51*	*5.4%*	*42*	*8.4%*	*9*	*2.0%*

[∂] These variables will be used for further analysis.

Eighty eight people (9.4%) also provided a description of their most recent episode of self-harm. This more conservative prevalence will be referred to as self-harm (validated). This variable is comparable to self-harm meeting the CASE study criteria (Hawton et al. 2002;Hawton et al. 2006), supporting hypothesis A1, to be discussed in Chapter 9. Self-harm (validated) was reported by 3.3% of males and 15.5% of females in the Phase 3 sample, and 51 participants (58% of those who met the study validation criteria) had self-harmed in the past year (9 males and 42 females). Further analyses for this category of self-harm will exclude the 34 participants who did not give further information describing their most recent episode of self-harm.

The prevalence estimates were checked with data weighted to be representative of the young people attending secondary schools in Newham, Tower Hamlets and Hackney. The prevalence did not change substantially with weighting; 9.4% for self-harm (validated), 13.1% for self-harm (Y/N) and 7.3% for self-harm (Y/N in the past 12 months). As this was similar to the unweighted prevalence estimates, further analysis was not weighted.

Univariate analysis indicated very strong evidence for an association between being female and self-harm. See Table 6. The odds for self-harm in females were higher and the confidence interval was wider for validated self-harm (OR 5.4, 95%CI 3.00-9.72, p<0.001) and the 12 month prevalence of self-harm (OR 3.32, 95%CI 1.84-5.98, p<0.001).

Table 6: Frequency and univariate odds ratios for gender at Phase 3 in association with lifetime self-harm and self-harm in the past 12 months

Exposure Variable		***Self-harm (validated) N=905***				***Self-harm in past 12 months N=939***			
Phase 3		***N***	***%[a]***	***OR***	***95% CI***	***N***	***%[a]***	***OR***	***95% CI***
Gender	*Male*	*14*	*3.3*	*1*		*15*	*3.4*	*1*	
	Female	*74*	*15.5*	***5.40****	***3.00-9.72***	*53*	*10.6*	***3.32****	***1.84-5.98***
Total		*88*				*68*			

[a] The counts and percentages given are by row; percentage within each category of the exposure variable.
** p<0.05*, **** p<0.01**, ****** p<0.001***

Methods and motivations for self-harm

To further describe the self-harm reported in the survey, this section outlines methods and motivations for self-harm. The details about the most recent episode were coded into categories by method of self-harm, shown in Table 7. The distribution of methods reported was similar in males and females, with self cutting and overdoses being the most common methods used. Table 8 presents the motives given by those who had self-harmed, assessed using a closed response question with nine response options. Participants were invited to choose all options which applied, and thus able to report more than one motivation for their most recent episode. The most common motive was to get relief from a terrible state of mind, followed by wishing to die and a wish for self-punishment.

Suicidal ideation

Looking at suicidal ideation reported for the last occasion of self-harm, a wish to die was reported by 34 (38.5%) of those who had self-harmed and met the study validation criteria. Regarding those who had self-harmed in the past year, 22 (32.3% of those who had ever self-harmed) reported a wish to die in their last attempt.

Table 7: Methods of self-harm in RELACHS Phase 3

Method of self-harm	Method of harm reported by females	Method of harm reported by males	Total number of people reporting each method	
	n[+]	n[+]	n	%[∂]
Self Cutting	49	6	55	*62.5*
Overdose	23	5	28	*31.8*
Burning	1	1	2	*2.3*
Self Battery	0	1	1	*1.1*
Recreational use of opiates/heroin	0	1	1	*1.1*
Drowning	1	0	1	*1.1*
Total	74	14	88	*100*

[∂] The percentages are out of the participants who reported validated self-harm (n=88).
[+] Percentages were not given by gender due to the small numbers of participants in each category.

Table 8: Reasons given for most recent episode of self-harm

	Self-harm (validated)	
I wanted:	***n***	***%*** [∂]
To show how desperate I was feeling	*17*	*19.3*
To die	*34*	*38.6*
To punish myself	*24*	*27.3*
To frighten someone	*4*	*4.5*
To get my own back on someone	*1*	*1.1*
To get relief from a terrible state of mind	*40*	*45.5*
To find out if someone really loved me	*8*	*9.1*
To get some attention	*5*	*5.7*
Other reason	*25*	*28.4*

[∂] The percentages are out of the participants who reported validated self-harm (n=88).

5.2.3. Hypothesis A2: Ethnicity

The prevalence of self-harm will not vary by ethnicity in this adolescent sample.

5.2.3.1. Cross-sectional analyses (Phase 3)

The prevalence of self-harm by Phase 3 ethnic group is presented in Table 9. Regarding ethnicity, the Asian British group had increased odds for self-harm in the 12 months prior to Phase 3, compared with the White group (OR 2.44, 95%CI 1.10-5.41, $p<0.05$). There were no other significant differences between ethnic groups. In analysis adjusted for gender, there were no changes to the significance of the associations between self-harm and ethnicity. There were no significant interactions between ethnicity and gender in relation to any of the self-harm categories, irrespective of whether the missing data on exposure variables was included as a category.

5.2.3.2. Longitudinal analyses (Phases 2 & 3)

As the Asian British ethnic group was not a category used in the Phase 2 assessment of ethnicity, analysis was conducted using ethnic groups reported at Phase 2, shown in Table 10. Results showed no significant associations between self-harm and any ethnic group reported at Phase 2. These associations did not change with adjustment for gender.

Table 9: Frequency and univariate odds ratios for ethnicity at Phase 3 in association with lifetime self-harm and self-harm in the preceding 12 months

Exposure Variable		***Self-harm (validated) N=905***				***Self-harm in past 12 months N=939***			
Phase 3		***N***	***%[e]***	***OR***	***95% CI***	***N***	***%[e]***	***OR***	***95% CI***
Ethnic groups	*White*	*26*	*11.3*	*1*		*20*	*8.4*	*1*	
	Bangladeshi	*15*	*7.7*	*0.65*	*0.33-1.27*	*10*	*5.0*	*0.57*	*0.26-1.24*
	Black	*16*	*8.4*	*0.72*	*0.38-1.39*	*11*	*5.5*	*0.64*	*0.30-1.36*
	Asian Indian	*8*	*11.9*	*1.06*	*0.46-2.47*	*8*	*11.8*	*1.45*	*0.61-3.45*
	Pakistani	*4*	*6.0*	*0.50*	*0.17-1.48*	*5*	*7.1*	*0.84*	*0.30-2.31*
	Asian British	*11*	*20.0*	*1.96*	*0.90-4.27*	*11*	*18.3*	*2.44**	*1.10-5.41*
	Other	*8*	*8.0*	*0.68*	*0.30-1.56*	*3*	*2.9*	*0.33*	*0.10-1.12*
Total		*88*				*68*			

[e] The counts and percentages given are by row; percentage within each category of the exposure variable.
* *p<0.05*, **** p<0.01**, ***** *p<0.001***

Table 10: Frequency and univariate odds ratios for ethnicity at Phase 2 in association with self-harm in the preceding 12 months

Exposure Variable		***Self-harm in past 12 months N=807***			
Phase 2		***N***	***%[e]***	***OR***	***95% CI***
Ethnic groups	*White -UK*	*10*	*6.8*	*1*	
	White Other	*6*	*12.0*	*1.86*	*0.64-5.39*
	Bangladeshi	*16*	*7.7*	*1.14*	*0.50-2.59*
	Black	*7*	*4.2*	*0.60*	*0.22-1.62*
	Asian Indian	*7*	*9.9*	*1.49*	*0.54-4.09*
	Pakistani	*1*	*1.7*	*0.23*	*0.03-1.87*
	Mixed race	*6*	*10.7*	*1.63*	*0.56-4.72*
	Other	*4*	*8.2*	*1.21*	*0.36-4.04*
	Missing data	*1*	*33.3*	*--*	*--*
Total		*58*			

[e] The percentages given are by row; percentage within each category of the exposure variable.

* *p<0.05*, **** p<0.01**, ***** *p<0.001***

5.2.4. Hypothesis A3: Socio-economic status

The prevalence of self-harm will not vary with socio-economic status in this sample.

5.2.4.1. Cross-sectional analyses (Phase 3)

Cross-sectional associations between self-harm, family, socio-economic and socio-demographic factors are presented in Table 11. Living in an overcrowded home reduced the odds of self-harm, compared with those not living in overcrowded homes, however, this was only significant for validated self-harm (OR 0.56, 95%CI 0.32-0.98, p<0.05). No

other family or demographic factors were associated with self-harm in cross-sectional analyses. Adjustment for gender led to no alteration to the unadjusted findings.

Each demographic variable and self-harm category combination was assessed for an interaction with gender. There were no significant interactions (using $p<0.05$ as an indicator of significance), thus the relationships between these demographic variables and self-harm did not vary by gender in this sample.

5.2.4.2. Longitudinal analyses (Phases 2 & 3)

There were no significant associations between demographic variables at Phase 2 and self-harm in the 12 months before Phase 3 (assessing significance as $p<0.05$), as shown in Table 12. There were no significant interactions between gender (at Phase 3) and these demographic variables for self-harm.

Table 11: Frequency and univariate odds ratios for Phase 3 family and demographic factors in association with lifetime self-harm and self-harm in the preceding 12 months

Exposure Variables		***Self-harm (validated)***				***Self-harm in the past 12 months***			
Phase 3		***N***	***%***	***OR***	***95% CI***	***N***	***%***	***OR***	***95% CI***
Parental employment	*At least one parent employed*	*54*	*9.9*	*1*		*42*	*7.5*	*1*	
	Neither parent employed	*28*	*9.9*	*0.77*	*0.32-1.85*	*22*	*7.4*	*0.99*	*0.58-1.69*
	Missing	*6*	*7.8*	*--*	*--*	*4*	*5.1*	*--*	*--*
Eligible for free school meals (FSM)	*Not eligible*	*46*	*10.3*	*1*		*31*	*6.8*	*1*	
	Eligible	*40*	*9.3*	*0.89*	*0.57-1.39*	*36*	*8.0*	*1.20*	*0.73-1.97*
	Missing	*2*	*6.7*	*--*	*--*	*1*	*3.2*	*--*	*--*
Household composition Lives with:	*Both parents*	*48*	*8.9*	*1*		*36*	*6.5*	*1*	
	Neither parent	*1*	*11.1*	*1.28*	*0.16-10.44*	*1*	*10*	*1.61*	*0.20-13.05*
	Only 1 parent	*21*	*13.3*	*1.57*	*0.91-2.71*	*12*	*7.2*	*1.13*	*0.57-2.22*
	Missing	*18*	*9.0*	*--*	*--*	*19*	*9.2*	*--*	*--*
Over-crowding at home[e]	*Not overcrowded*	*65*	*11.1*	*1*		*47*	*7.8*	*1*	
	Overcrowded	*17*	*6.6*	*0.56**	*0.32-0.98*	*19*	*7.0*	*0.90*	*0.52-1.56*
	Missing	*6*	*9.5*	*--*	*--*	*2*	*3.1*	*--*	*--*
Total		*88*				*68*			

[e] Overcrowding is defined as more than 1.5 people per room in the household. ** p<0.05*, **** p<0.01**, ****** p<0.001***

Table 12: Frequency and univariate odds ratios for Phase 2 family and demographic factors in association with self-harm in the preceding 12 months

Exposure Variable		***Self-harm in the past 12 months***			
Phase 2		***N***	***%***	***OR***	***95% CI***
Parental employment	*At least one parent employed*	*41*	*7.7*	*1*	
	Neither parent employed	*17*	*7.0*	*0.90*	*0.50-1.61*
	Missing	*0*	*0*	*--*	*--*
Eligible for free school meals (FSM)	*Not eligible*	*27*	*6.6*	*1*	
	Eligible	*30*	*7.8*	*1.20*	*0.70-2.06*
	Missing	*1*	*10.0*	*--*	*--*
Household composition Lives with:	*Both parents*	*43*	*7.1*	*1*	
	Neither parent	*0*	*0*	*--*	*--*
	Only 1 parent	*15*	*9.0*	*1.30*	*0.70-2.40*
	Missing	*0*	*0*	*--*	*--*
Over-crowding at home[e]	*Not overcrowded*	*36*	*7.3*	*1*	
	Overcrowded	*22*	*7.7*	*1.07*	*0.62-1.86*
	Missing	*0*	*0*	*--*	*--*
Total		*58*			

[e] Overcrowding defined as more than 1.5 people per room in the household.

5.2.5. Summary of key findings for section 5.2.

The lifetime prevalence of self-harm (Y/N) was 13% for the whole sample, and 9.4% using the validated assessment. Within the Phase 3 sample, 7.3% of participants reported an episode of self-harm within the past 12 months. Around one third of those who had self-harmed reported suicidal ideation accompanying their most recent episode.

Participants who described themselves as Asian British at Phase 3 had increased odds for self-harm in the preceding 12 months. This association was weak. There were no associations between ethnicity and self-harm (validated), nor between self-harm and any of the ethnic groups reported at Phase 2.

There was weak evidence that if a young person lived in an overcrowded home, they had reduced odds for self-harm. There were no significant associations between socio-economic status and self-harm.

5.3. Psychological distress and depressive symptoms

5.3.1. Hypothesis B1: Psychological distress and depressive symptoms

High levels of current and previous psychological distress and depressive symptoms will be associated with self-harm at age 15-16 years.

Analyses for this hypothesis will use both cross-sectional and longitudinal results, incorporating the different aspects of mental health assessed in RELACHS in Phase2 and Phase 3. Variables used to test this hypothesis were scores from the Short Moods and Feelings Questionnaire (SMFQ), the Strengths and Difficulties Questionnaire (SDQ) total score, emotional symptoms and conduct problems subscales. Unadjusted analyses will be presented first, followed by adjusted analysis. Each of the significant univariate results was adjusted for gender, eligibility for free school meals (as a proxy for socio-economic status) and ethnicity. Significant results for the validated and 12 month self-harm variables were examined further.

5.3.1.1. Cross-sectional analyses (Phase 3)

Assessments of psychological distress and depressive symptoms

Table 13 presents the prevalence of mental health as assessed in Phase 3. Ten percent of this sample was above the caseness threshold for the Strengths and Difficulties Questionnaire (SDQ). A further 23.2% of the sample scored in the borderline category, indicating that over one third of this sample reported elevated levels of psychological distress. One quarter of the participants were rated as cases for the emotional symptoms and conduct problems SDQ sub-scales. One third of the sample also reported depressive symptoms, indicated by caseness on the Short Moods and Feelings Questionnaire (SMFQ).

Comorbidity identified by the different mental health assessments at Phase 3 are shown in Table 14. In this analysis, 73.4% of the SDQ cases were also SMFQ cases, however, only 22.5% of SMFQ cases were also SDQ cases. This illustrates that SDQ caseness has a broader scope than the SMFQ. Alternatively, the SDQ may have a relatively lower threshold for “caseness” than the MFQ. 75 participants were cases for both emotional

symptoms and conduct problems (32.3% of each subscale). 45.7% of those with conduct problems were also SMFQ cases (n=106), indicating some comorbidity.

Table 13: Prevalence of mental health cases from assessments in Phase 3

Mental health assessments		**RELACHS Phase 3 participants**	
Phase 3 Variables	**Variable Categories**	**n ǂ**	**% ǂ**
Psychological distress (SDQ)	Not Case	622	66.2
	Borderline	218	23.2
	Case	94	10.0
	Missing	*5*	*0.5*
Emotional Symptoms (SDQ subscale)	Not Case	583	62.1
	Borderline	119	12.7
	Case	232	24.7
	Missing	*5*	*0.5*
Conduct Problems (SDQ subscale)	Not Case	562	59.9
	Borderline	140	14.9
	Case	232	24.7
	Missing	*5*	*0.5*
Depressive symptoms (SMFQ caseness)	Not Case	628	66.9
	Case	306	32.6
	Missing	*5*	*0.5*
Total		**939**	**100**

ǂ Frequencies and percentages are given by column, separately for each variable, using unweighted data.

Table 14: Frequency and percentage of participants who were cases for each mental health assessment at Phase 3

Phase 3 variables	***SDQ total scale cases Phase 3ǂ***	***Conduct Problem cases Phase 3ǂ***	***Emotional Symptoms cases Phase 3ǂ***
	n *(column %)* *(row %)*	*n* *(column %)* *(row %)*	*n* *(column %)* *(row %)*
Conduct Problems cases (SDQ subscale)	*71* *(75.5% of SDQ cases)* *(30.6% of conduct cases)*	*	*
Emotional Symptoms (SDQ subscale)	*74* *(78.7% of SDQ cases)* *(31.9% of emotional cases)*	*75* *(32.3% of conduct cases)* *(32.3% of emotional cases)*	*
Depressive symptoms (SMFQ caseness)	*69* *(73.4% of SDQ cases)* *(22.5% of SMFQ cases)*	*106* *(45.7% of conduct cases)* *(34.6% of SMFQ cases)*	*148* *(63.8% of emotional cases)* *(48.4% of SMFQ cases)*

ǂAnalyses were conducted using the whole analysis sample (N=939).

Associations between psychological distress and self-harm

Table 15 presents the prevalence and univariate odds ratios for SDQ scores in relation to self-harm. There was very strong evidence that psychological distress was associated with self-harm. The odds of validated self-harm were almost four times higher amongst SDQ cases compared with non-cases (OR 3.92 95%CI 2.09-7.34, p<0.001). The borderline group had similar odds of self-harm to the SDQ cases, indicating that moderate levels of psychological distress were associated with an increased likelihood of self-harm. Adjustment for demographic factors had little impact. For Phase 3 SDQ caseness, there was a slight influence on the effect size and no change in the significance of the

associations, for example, the adjusted odds ratio for SDQ caseness in association with self-harm (validated) increased slightly to 3.98 (95%CI 2.07-7.64, p<0.001).

Table 15: Frequency and univariate odds ratios for psychological distress (SDQ caseness) at Phase 3 in association with lifetime self-harm and self-harm in the past 12 months

Exposure Variable		**Self-harm (validated)** ***N=905***				**Self-harm in past 12 months** ***N=939***			
Phase 3		**N**	**%** [e]	**OR**	**95% CI**	**N**	**%** [e]	**OR**	**95% CI**
SDQ	Not Case	36	5.9	1		22	3.5	1	
	Borderline	35	17.0	***3.25*** ***	***1.98-5.34***	29	13.3	***4.19*** ***	***2.35-7.46***
	Case	17	19.8	***3.92*** ***	***2.09-7.34***	17	18.1	***6.02*** ***	***3.06-11.84***
	Missing	*0*	*0*	--	--	*0*	*0*	--	--
Total									

[e] The percentages given are by row; percentage within each category of the exposure variable.
* p<0.05, ** **p<0.01,** *** ***p<0.001***

Repeated analysis for the total SDQ scale using an alternative threshold

The above univariate analyses were conducted using the threshold from a UK sample of adolescents (Meltzer et al. 2000;Stansfeld et al. 2003). At 10%, the prevalence of SDQ caseness in this sample was similar to the study from which the threshold was drawn. Analysis was also conducted using the suggested total scale cut-offs for caseness and borderline from the SDQ website. As the website cut-offs were more conservative, fewer participants were rated as borderline and cases, and a higher proportion of those participants had self-harmed. The odds ratios for self-harm (validated) using the website cut-offs were similar to the study cut-offs; borderline (OR 3.40; 95%CI 2.01-5.77) being slightly higher than for caseness (OR 3.25; 95%CI 1.42-7.43). These analyses illustrate that even with two different thresholds, increased psychological distress identified as case or borderline on the SDQ has increased odds for self-harm in univariate analysis.

SDQ subscales

There was strong evidence (p<0.01) for case-level conduct problems being associated with both self-harm categories. See Table 16. There was also an association between borderline conduct problems and self-harm in the preceding 12 months (p<0.01). Adjustment for gender, ethnicity and eligibility for free school meals had the effect of increasing the odds for Phase 3 conduct disorder in association with validated self-harm and self-harm in the past 12 months. For cases with conduct problems, the odds for self-harm (validated) rose from 2.00 (95%CI 1.22-3.25, p<0.01) in unadjusted analysis to 2.90 (95%CI 1.72-4.88, p<0.001) in adjusted analysis. Similarly, for self-harm in the past 12 months, the unadjusted odds ratios for conduct cases were 3.33 (95%CI 1.90-5.83, p<0.001) and this changed to an odds ratio of 4.48 (95%CI 2.50-8.01, p<0.001) in adjusted analysis.

Both borderline scores and caseness on the emotional symptoms subscale were significantly associated with self-harm. This scale indicated a dose-response relationship with higher odds for cases compared with borderline scores. For example, for self-harm (validated), borderline emotional symptoms had an odds ratio of 2.43 (95%CI 1.22-4.84, p<0.05) and cases had an odds ratio of 5.06 (95%CI 3.08-8.30, p<0.001).

Table 16: Frequency and univariate odds ratios for emotional symptoms and conduct problems (SDQ subscales) at Phase 3 in association with lifetime self-harm and self-harm in the past 12 months

Exposure Variable		**Self-harm (validated)** ***N=905***				**Self-harm in past 12 months** ***N=939***			
Phase 3 variables		**N**	**%**[e]	**OR**	**95% CI**	**N**	**%**[e]	**OR**	**95% CI**
Conduct Problems	Not Case	43	7.8	1		24	4.3	1	
	Borderline	14	10.4	1.38	0.73-2.60	14	10.0	**2.49****	**1.25-4.95**
	Case	31	14.4	**2.00****	**1.22-3.25**	30	12.9	**3.33*****	**1.90-5.83**
	Missing	*0*	*0*	--	--	*0*	*0*	--	--
Emotional Symptoms	Not Case	29	5.1	1		19	3.3	1	
	Borderline	13	11.5	*2.43**	*1.22-4.84*	10	8.4	*2.72**	*1.23-6.02*
	Case	46	21.3	***5.06*****	***3.08-8.30***	39	16.8	***6.00*****	***3.39-10.63***
	Missing	*0*	*0*	--	--	*0*	*0*	--	--
Total		88				68			

[e] The percentages given are by row; percentage within each category of the exposure variable.
p<0.05*, ****p<0.01*, *****p<0.001*

Table 17 presents univariate analysis for the Short Moods and Feelings Questionnaire (SMFQ). There was very strong evidence (p<0.001) for an association between depressive symptoms and self-harm, with SMFQ cases being 6.58 times as likely to report self-harm (validated), with a 95%CI of 4.06-10.67.

For both the Phase 3 emotional symptoms SDQ subscale and SMFQ caseness, the odds of validated lifetime self-harm and self-harm in the past 12 months decreased slightly with adjustment for gender, ethnicity and eligibility for free school meals. There were no changes to the level of significance in the associations. There were no significant interactions between gender and any of the exposure variables for any of the associations, irrespective of whether the missing data was coded as a category or excluded from this cross-sectional analysis.

Table 17: Frequency and univariate odds ratios for depressive symptoms (MFQ caseness) at Phase 3 in association with lifetime self-harm and self-harm in the past 12 months

Exposure Variable		**Self-harm (validated)** ***N=905***				**Self-harm in past 12 months** ***N=939***			
		N	**%** [e]	**OR**	**95% CI**	**N**	**%** [e]	**OR**	**95% CI**
SMFQ	Not case	26	4.2	1		12	1.9	1	
	Case	62	22.3	***6.58*** ***	***4.06-10.67***	56	18.3	***11.50*** ***	***6.06-21.82***
	Missing	*0*	*0*	--	--	*0*	*0*	--	--
Total		88				68			

[e] The percentages given are by row; percentage within each category of the exposure variable.
* *p<0.05*, **** p<0.01, *** *p<0.001***

5.3.1.2. Longitudinal analyses (Phases 2 & 3)

Table 18 presents the prevalence of mental health caseness from Phase 2. Comparing across phases, the prevalence of SDQ total and subscale caseness were similar in Phases 2 and 3, while rates of SMFQ caseness were lower in Phase 2. Table 19 presents a summary of caseness for the mental health assessments over Phase 2 and Phase 3. In the longitudinal sample being used in this analysis 56.3% of the SMFQ cases at Phase 2, were SMFQ cases at Phase 3. Of the SMFQ cases at Phase 3, 38.8% had been SMFQ cases at Phase 2, which was 16.5% of the entire longitudinal sample.

Table 18: Prevalence of mental health cases from assessments in Phase 2

Mental health assessments		**RELACHS Phase 3 participants**	
Phase 2 Variables	**Variable Categories**	**N**	**%** [‡]
Psychological distress (SDQ)	Not Case	509	63.1
	Borderline	201	24.9
	Case	78	9.7
	Missing	*19*	*2.4*
Emotional Symptoms (SDQ subscale)	Not Case	503	62.3
	Borderline	111	13.8
	Case	173	21.4
	Missing	*20*	*2.5*
Conduct Problems (SDQ subscale)	Not Case	446	55.3
	Borderline	142	17.6
	Case	200	24.8
	Missing	*19*	*2.4*
Depressive symptoms (SMFQ caseness)	Not Case	566	70.1
	Case	168	20.8
	Missing	*73*	*9.0*
Total		**807**	**100**

[‡]Percentages are given by column, for each variable.

Table 19: Longitudinal prevalence of SDQ and SMFQ caseness

Longitudinal caseness for mental health assessments	*Never a case*		*Case at Phase 2 only*		*Case at Phase 3 only*		*Case at both Phases 2 & 3*		*Missing data*	
	n	*(%)[ɵ]*	*n*	*(%)[ɵ]*	*n*	*(%)[ɵ]*	*n*	*(%)[ɵ]*	*n*	*(%)[ɵ]*
Psychological distress (SDQ)	*665*	*(82.4)*	*48*	*(5.9)*	*48*	*(5.9)*	*30*	*(3.7)*	*16*	*(2.0)*
Emotional Symptoms (SDQ subscale)	*521*	*(64.6)*	*85*	*(10.5)*	*98*	*(12.1)*	*88*	*(10.9)*	*15*	*(1.9)*
Conduct Problems (SDQ subscale)	*511*	*(63.3)*	*89*	*(11.0)*	*85*	*(10.5)*	*111*	*(13.8)*	*11*	*(1.4)*
Depressive symptoms (SMFQ caseness)	*432*	*(53.5)*	*94*	*(11.6)*	*73*	*(9.0)*	*133*	*(16.5)*	*75*	*(9.3)*

[ɵ] Percentages are of the longitudinal sample (n=807), presented by row, within each assessment.

Comorbidity

Comorbidity between mental health assessments at Phase 2 is shown in Table 20. The proportion of SMFQ cases who were also cases on the SDQ scales was similar to that for Phase 3; 26.8% were also SDQ cases, 39.9% also had conduct problems and 55.4% had emotional symptoms. There was a lower proportion of the SDQ scale and sub-scale cases who were also SMFQ cases compared with Phase 3.

Table 20: Frequency and percentage of participants who were cases for each mental health assessment at Phase 2

Phase 2 variables	***SDQ total scale cases Phase 2[ǂ]***	***Conduct Problem Cases Phase 2[ǂ]***	***Emotional Symptoms Cases Phase 2[ǂ]***
	n *(column %)* *(row %)*	*n* *(column %)* *(row %)*	*N* *(column %)* *(row %)*
Conduct Problems cases (SDQ subscale)	*61* *(78.2% of SDQ cases)* *(30.5% of conduct cases)*	*	*
Emotional Symptoms (SDQ subscale)	*56* *(71.8% of SDQ cases)* *(32.4% of emotional cases)*	*59* *(29.5% of conduct cases)* *(34.1% of emotional cases)*	*
Depressive symptoms (SMFQ caseness)	*45* *(57.7% of SDQ cases)* *(26.8% of SMFQ cases)*	*67* *(33.5% of conduct cases)* *(39.9% of SMFQ cases)*	*93* *(53.8% of emotional cases)* *(55.4% of SMFQ cases)*

[ǂ]Analyses were conducted using the whole analysis sample (N=807).

The proportions of participants in each Phase 2 mental health category who had self-harmed are shown in Tables 21-24. Table 21 presents regression analyses for the SDQ total scale and self-harm. There were no significant associations between SDQ caseness at Phase 2 and self-harm in the 12 month preceding Phase 3.

Table 21: Frequency and univariate odds ratios for psychological distress (SDQ caseness) at Phase 2 in association with self-harm in the past 12 months

Exposure Variable		**Self-harm in past 12 months *N=807***			
Phase 2 variable		**N**	**%**[e]	**OR**	**95% CI**
SDQ	Not Case	31	6.1	1	
	Borderline	20	10.0	1.70	0.95-3.07
	Case	5	6.4	1.06	0.40-2.80
	Missing	*2*	*10.5*	*1.81*	*0.40-8.21*
Total		58			

[e] The counts and percentages given are by row; percentage within each category of the exposure variable.
* *p<0.05*, **** p<0.01, *** *p<0.001***

Table 22 presents longitudinal regression analysis for the Phase 2 SDQ subscales. There was weak evidence (p<0.05) for conduct problems at Phase 2 being associated with self-harm in the past 12 months prior to Phase 3. The odds of self-harm in the past 12 months increased slightly for participants who had conduct problems with adjustment for socio-demographic factors, from 1.87 (95%CI 1.01-3.46, p<0.05) to 2.19 (95%CI 1.17-4.10, p<0.05).

There was good evidence for caseness on emotional symptoms being associated with self-harm in the past 12 months (OR 2.64, 95%CI 1.44-4.85, p<0.01). Adjustment for gender, ethnicity and eligibility for free school meals did not alter the significance of the longitudinal association, however, it reduced the odds for the relationship between Phase 2 emotional symptoms and self-harm (validated) and self-harm in the past 12 months to 2.08 (95%CI 1.11-3.88, p<0.05).

The analysis of depressive symptoms using the SMFQ is presented in Table 23. There was a significant univariate association between Phase 2 SMFQ caseness and self-harm in the past 12 months (OR 2.24, 95%CI 1.26-3.97, p<0.01).

Table 22: Frequency and univariate odds ratios for emotional symptoms and conduct problems (SDQ subscales) at Phase 2 in association with self-harm in the past 12 months

Exposure Variables		**Self-harm in past 12 months *N=807***			
Phase 2 variables		**N**	**%**[e]	**OR**	**95% CI**
Conduct Problems	Not Case	25	5.6	1	
	Borderline	11	7.7	1.41	1.01-3.46
	Case	20	10.0	*1.87**	*1.01-3.46*
	Missing	*2*	*10.5*	--	--
Emotional Symptoms	Not Case	25	5.0	1	
	Borderline	10	9.0	1.89	0.88-4.07
	Case	21	12.1	**2.64****	**1.44-4.85**
	Missing	*2*	*10.0*	--	--
Total					

[e] The percentages given are by row; percentage within each category of the exposure variable.
* *p<0.05*, **** p<0.01, *** *p<0.001***

Table 23: Frequency and univariate odds ratios for depressive symptoms (MFQ caseness) at Phase 2 in association with self-harm in the past 12 months

Exposure Variable		**Self-harm in past 12 months *N=807***			
		N	**%[e]**	**OR**	**95% CI**
SMFQ	Not case	34	6.0	1	
	Case	21	12.5	**2.24****	**1.26-3.97**
	Missing	*3*	*4.1*	--	--
Total					

[e] The percentages given are by row; percentage within each category of the exposure variable.
* p<0.05, ** **p<0.01**, *** ***p<0.001***

Analysis tested for interactions between Phase 2 mental health exposures and gender in relation to self-harm in the year preceding Phase 3. Only one set of analyses showed a significant interaction. This interaction was between gender and being an SMFQ case at Phase 2 within the analysis for self-harm in the past 12 months ($p<0.05$). This analysis was conducted again separately for males and females.

There were 379 males in the longitudinal analyses, including 14 participants who had self-harmed in the past year. There were 55 males who had been Phase 2 SMFQ cases, and seven (12.7%) of those participants had self-harmed in the past year. Univariate regression indicated that, for males, SMFQ caseness at Phase 2 predicted self-harm in the year preceding Phase 3 (OR 6.40, 95%CI 2.14-20.60, p=0.01). The relationship between Phase 2 SMFQ and self-harm in the past 12 months remained significant for males when adjusted for ethnicity and eligibility for free school meals. Due to the small number of participants who had self-harmed, this finding was not explored further. In comparison, there were 428 females in the longitudinal analysis. There were 113 females who had been cases on the SMFQ at Phase 2, and 44 females who reported self-harming in the past year. 12.4% of those who were Phase 2 SMFQ cases had self-harmed in the past year, and this was not significant in univariate regression analyses.

This stratified analysis showed that self-harm in the past 12 months was clearly associated with earlier reports of high depressive symptoms in males, but not for females.

5.3.1.3. Summary of univariate analyses showing associations with self-harm

To summarise the significant univariate results; in cross sectional analysis using the validated self-harm category, there were significant associations for caseness and borderline scores on the SDQ total scale and emotional symptoms subscales. There were also significant associations between caseness for the conduct SDQ subscale and caseness on the SMFQ. Using the 12 month self-harm category, cross-sectional analyses

showed univariate associations with caseness and borderline scores for the SDQ total scale, both subscales and also for SMFQ caseness.

Longitudinal analysis showed that self-harm in the past 12 months was predicted by caseness on the emotional symptoms and conduct problems subscale, but not the total SDQ scale. Self-harm in the past year was predicted by SMFQ caseness in whole sample analysis and in males but not females.

5.3.1.4. Adjusted analyses (Phases 2 & 3)

More recent psychological distress and depressive symptoms are likely to exert a more powerful effect than previous psychological distress and depressive symptoms on self-harm. However, to explore the strength of prospective associations between these factors and self-harm, analysis was conducted to assess whether the relationships between Phase 2 mental health and self-harm in the past year remained significant when accounting for Phase 3 mental health. Each longitudinal association was adjusted for the equivalent scale at Phase 3. The longitudinal associations between self-harm in the past year, Phase 2 conduct problems and SMFQ and were accounted for by the equivalent scale at Phase 3. In each model, shown in Table 24, the Phase 3 exposure remained significant. To give an example, as the Phase 2 SDQ emotional symptoms subscale had a significant association with self-harm in the past 12 months, Phase 3 emotional symptoms were added to that regression model. The longitudinal association between self-harm and emotional symptoms at Phase 2 became non-significant (OR 1.09, 95%CI 0.55-2.16), and the association with Phase 3 emotional symptoms remained significant with a five-fold increase in the odds for self-harm in the past 12 months (95%CI 2.50-10.41, $p<0.001$), see Model C in Table 24.

Regarding psychological distress (Model A), adjusted models showed that Phase 3 SDQ caseness as a strong relationship with self-harm (validated) and in the past 12 months. In the model for associations with self-harm in the past 12 months, Phase 3 SDQ caseness was associated with an eight-fold increase in the odds for self-harm (OR 8.47, 95%CI 3.55-20.21, $p<0.001$).

Table 24: Odds ratios for self-harm in the past 12 months adjusted for Phase 2 and Phase 3 mental health

Phase 2 & Phase 3 Exposure variables		**Self-harm in past 12 months *N=807***	
		Adjusted‡ OR & 95%CI	**Adjusted◊ OR & 95%CI**
Model A			
SDQ total scale Phase 2	Not Case	1	1
	Borderline	1.78 (0.98-3.24)	0.82 (0.42-1.62)
	Case	0.97 (0.36-2.61)	*0.31* (0.10-0.92)*
SDQ total scale Phase 3	Not Case	--	1
	Borderline	--	***4.58*** (2.33-9.00)***
	Case	--	***8.47*** (3.55-20.21)***
Model B			
Conduct Problems Phase 2	Not Case	1	1
	Borderline	1.62 (0.77-3.42)	1.24 (0.57-2.70)
	Case	*2.19* (1.17-4.10)*	1.21 (0.59-2.52)
Conduct Problems Phase 3	Not Case	--	1
	Borderline	**--**	1.96 (0.87-4.39)
	Case	**--**	**3.26**¤ (1.60-6.64)**
Model C			
Emotional Symptoms Phase 2	Not Case	1	1
	Borderline	1.64 (0.76-3.56)	1.01 (0.45-2.28)
	Case	*2.08* (1.11-3.88)*	1.09 (0.55-2.16)
Emotional Symptoms Phase 3	Not Case	--	1
	Borderline	--	*2.78* (1.18-6.51)*
	Case	--	***5.10*** (2.50-10.41)***
Model D			
SMFQ scale Phase 2	Not Case	1	1
	Case	*2.99* (1.11-3.58)*	1.04 (0.56-1.94)
SMFQ scale Phase 3	Not Case	--	1
	Case	--	***12.56*** (6.01-26.26)***

‡ Adjusted for gender, eligibility for free school meals and ethnicity.
◊ Adjusted for gender, eligibility for free school meals and ethnicity, and the repeated assessment at Phase 3.
* *p<0.05,* **** p<0.01,** ****¤ p=0.001**, ***** *p<0.001***

As an alternate test of the longitudinal relationship between self-harm and mental health, composite variables were derived with categories for participants who had never been cases, were cases at Phase 2 only, Phase 3 only, or at both Phases. Analysis of these exposures is presented in Tables 25-27. These results highlight the strong relationships between depressive symptoms reported at the same time as self-harm. This was particularly evident for depressive symptoms. The odds and confidence intervals for depressive symptoms in association with self-harm in the 12 months preceding Phase 3 were similar for Phase 3 caseness, irrespective of whether participants had also been cases at Phase 2. For example, the odds for Phase 3 only SDQ emotional symptoms caseness were 4.49 (95%CI 2.20-9.19, p<0.001) and the odds ratios for caseness at both Phases 2 and 3 were 4.34 (95%CI 2.07-9.13, p<0.001). Small numbers in each category have led to wide confidence intervals around point estimates for these analyses.

Table 25: Frequency and adjusted odds ratios for psychological distress (SDQ caseness) at Phase 2 and Phase 3 in association with self-harm in the past 12 months

Exposure Variable		**Self-harm in past 12 months *N=807***			
Phase 2 & 3 variable		**n**	**%** [e]	**OR**[‡]	**95% CI**
SDQ	Not a case at Phase 2 or 3	42	6.3	1	
	Case at Phase 2 only	1	2.1	0.29	0.04-2.20
	Case a Phase 3 only	10	20.8	***4.05*****[¤]	***1.84-8.91***
	Case at both Phases 2 &3	4	13.1	2.03	0.66-6.17
	Missing	*1*	*6.3*	--	--
Total		58			

[e] The counts and percentages given are by row; percentage within each category of the exposure variable.
[‡] Adjusted for gender, eligibility for free school meals and ethnicity.
*[¤] *p=0.05, * p<0.05,* ** **p<0.01,** **[¤] **p=0.001**, *** ***p<0.001***

Table 26: Frequency and adjusted odds ratios for emotional symptoms and conduct problems (SDQ subscales) at Phase 2 and Phase 3 in association with self-harm in the past 12 months

Exposure Variable		**Self-harm in past 12 months *N=807***			
Phase 2 & 3 variables		**n**	**%**[e]	**OR**[‡]	**95% CI**
Conduct Problems	Not a case at Phase 2 or 3	24	4.7	1	
	Case at Phase 2 only	9	10.1	*2.51****	*1.11-5.70*
	Case a Phase 3 only	13	15.3	***5.10*****	***2.40-10.84***
	Case at both Phases 2 &3	11	9.9	**2.86****	**1.33-6.16**
	Missing	*1*	*9.1*	--	--
Emotional Symptoms	Not a case at Phase 2 or 3	19	3.6	1	
	Case at Phase 2 only	6	7.1	1.66	0.63-4.36
	Case a Phase 3 only	17	17.3	***4.49*****	***2.20-9.18***
	Case at both Phases 2&3	15	17.0	***4.34*****	***2.07-9.13***
	Missing	*1*	*6.7*	--	--
Total		58			

[e] The percentages given are by row; percentage within each category of the exposure variable.
[‡] Adjusted for gender, eligibility for free school meals and ethnicity. * *p<0.05,* ** **p<0.01,** *** ***p<0.001***

Table 27: Frequency and adjusted odds ratios for depressive symptoms (MFQ caseness) at Phase 2 and Phase 3 in association with self-harm in the past 12 months

Exposure Variable		**Self-harm in past 12 months *N=807***			
		N	**%** [e]	**OR**[‡]	**95% CI**
SMFQ	Not a case at Phase 2 or 3	8	1.9	1	
	Case at Phase 2 only	2	2.7	1.51	0.31-7.35
	Case a Phase 3 only	26	19.5	***12.74*****	***5.43-29.96***
	Case at both Phases 2 &3	19	20.2	***12.79*****	***5.23-31.29***
	Missing	*3*	*4.0*	--	--
Total		58			

[e] The percentages given are by row; percentage within each category of the exposure variable.
[‡] Adjusted for gender, eligibility for free school meals and ethnicity. * *p<0.05,* ** **p<0.01,** *** ***p<0.001***

To ascertain which aspect of mental health had the strongest relationship with self-harm, models were built including the SDQ subscales and the SMFQ. Results for the adjusted cross-sectional and longitudinal analysis are presented in Tables 28 and 29, respectively. The SDQ subscales were not adjusted for the total scale as they constitute part of the total score. The association between SDQ caseness and self-harm (validated) was accounted for by SMFQ caseness (Model E, Table 28). This may relate to the co-morbidity shown between these scales, with three quarters of the Phase 3 SDQ cases also being Phase 3 SMFQ cases, shown in Table 14. This model also showed that people reporting moderate levels of psychological distress (borderline SDQ scores) had a two-fold increase in the odds of self-harm (validated), when SMFQ caseness was taken into account. Both SDQ subscales retained significant relationships with self-harm in analysis adjusted for depressive symptoms. SMFQ caseness showed a very strong association with self-harm (validated) despite adjustment for SDQ scales.

Table 28: Adjusted cross-sectional odds ratios for Phase 3 mental health scales in association with self-harm (validated) and self-harm in the past 12 months

Phase 3 Variables		**Self-harm (validated)** ***N=905***	**Self-harm in past 12 months** ***N=939***
Model E		**Adjusted∂ OR (95%CI)**	**Adjusted∂ OR (95%CI)**
SDQ total scale	Not Case	1	1
	Borderline	*2.01 (1.17-3.45)**	**2.36 (1.27-4.38)****
	Case	1.97 (0.98-3.98)	*2.50 (1.20-5.21)**
SMFQ total scale	Not Case	1	1
	Case	***4.12(2.42-7.02)****	***7.48 (3.77-14.87)****
Model F			
Conduct Problems	Not Case	1	1
	Borderline	1.08 (0.55-2.13)	1.76 (0.85-3.65)
	Case	*1.95 (1.12-3.38)**	**2.71 (1.47-5.01)****
SMFQ total scale	Not Case	1	1
	Case	***4.69 (2.81-7.82)****	***8.21 (4.21-16.01)****
Model G			
Emotional Symptoms	Not Case	1	1
	Borderline	1.52 (0.74-3.14)	1.60 (0.69-3.67)
	Case	**2.14 (1.23-3.72)****	**2.40 (1.28-4.50)****
SMFQ total scale	Not Case	1	1
	Case	***4.16 (2.46-7.03)****	***7.81 (3.95-15.42)****
Model H			
Conduct Problems	Not Case	1	1
	Borderline	1.35 (0.69-2.62)	*2.32 (1.13-4.73)**
	Case	**2.39 (1.40-4.09)**¤**	***3.60 (1.98-6.56)****
Emotional Symptoms	Not Case	1	1
	Borderline	1.79 (0.88-3.64)	2.05 (0.91-4.62)
	Case	***3.18 (1.89-5.37)****	***3.90 (2.13-7.13)****

∂ Adjusted for gender, eligibility for free school meals and ethnicity, separate models run for each comparison
* *p<0.05,* **** p<0.01, *** *p<0.001***

The odds ratios for self-harm Phase 3 SMFQ caseness in association with self-harm in the past 12 months increased with adjustment for Phase 3 SDQ scores. The associations

remained highly significant, with SMFQ cases having an odds ratio of 7.48 (95%CI 3.77-14.87) for self-harm. In the adjusted analysis, there were significant associations between self-harm and depressive symptoms, conduct problems and general psychological distress in the past 12 months, however the odds ratios were lower than in unadjusted models.

In longitudinal analysis, shown in Table 29, inclusion of each of the Phase 2 SDQ subscales (emotional symptoms and conduct problems) in regression models accounted for the association between Phase 2 SMFQ caseness and self-harm in the past 12 months. Conduct problems at Phase 2 showed a significant independent relationship with self-harm in the past 12 months (OR 1.94, 95%CI 1.02-3.71, $p<0.05$). In longitudinal analysis, the SMFQ and the emotional symptoms SDQ subscale do not have significant independent relationships with self-harm in the past 12 months, with each measure of emotional symptoms negating the effect of the other. The relationships between these scales and self-harm in the past 12 months differed from the cross-sectional analysis, where both scales remained significant after adjustment.

All assessments were checked for an interaction between the Phase 2 and Phase 3 measures. There were no significant interactions between Phase 2 and 3 mental health assessments for either self-harm category, which may stem from the high comorbidity between the assessments. It is also feasible that current depression could be a continuation of previous depression, so these more exploratory analyses may be over adjusted when examining longitudinal associations between mental health and self-harm.

Table 29: Adjusted longitudinal odds ratios for mental health assessments at Phase 2 in association with self-harm in the 12 months prior to Phase 3

Phase 2 Variables		**Self-harm in past 12 months *N=807***
Model I		**Adjusted[∂] OR & 95%CI**
SDQ total scale	Not Case	1
	Borderline	1.46 (0.77-2.77)
	Case	0.71 (0.25-2.03)
SMFQ total scale	Not Case	1
	Case	*1.91 (1.00-3.65)* [*¤]
Model J		
Conduct Problems	Not Case	1
	Borderline	1.45 (0.68-3.10)
	Case	*1.94 (1.02-3.71)* [*]
SMFQ total scale	Not Case	1
	Case	1.70 (0.93-3.11)
Model K		
Emotional Symptoms	Not Case	1
	Borderline	1.56 (0.70-3.45)
	Case	1.71 (0.84-3.47)
SMFQ total scale	Not Case	1
	Case	1.57 (0.81-3.04)
Model L		
Conduct Problems	Not Case	1
	Borderline	1.54 (0.73-3.27)
	Case	*2.00 (1.06-3.77)* [*]
Emotional Symptoms	Not Case	1
	Borderline	1.52 (0.70-3.33)
	Case	*1.89 (1.00-3.55)* [*]

[∂] Adjusted for gender, eligibility for free school meals and ethnicity, separate models run for each comparison
[*¤] *p=0.05, * p<0.05,* ** **p<0.01, *** *p<0.001***

5.3.2. Summary of key findings for section 5.3.

There was strong evidence that psychological distress, including depressive symptoms and conduct problems reported at age 15-16 was associated with lifetime and recent self-harm. However, the majority of people reporting psychological distress and depressive symptoms had not self-harmed.

There were longitudinal univariate associations between self-harm in the past twelve months, emotional symptoms, conduct problems and depressive symptoms. These relationships did not remain when the equivalent measures assessed at the same time as self-harm (Phase 3) were included in analyses (Table 24). Participants who were borderline and SDQ cases at Phase 3, had odds ratios of 4.5 and 8.5 for self-harm in the past 12 months (respectively), in analysis including previous and current psychological distress. This emphasises the strong relationship between current mental state and reporting self-harm. The significant association between borderline SDQ scores and self-

harm implies that self-harm is not solely associated with extreme levels of psychological distress, but also with moderate levels as well.

Conduct problems reported at age 13-14 (Phase 2) and 15-16 years (Phase 3) were associated with self-harm in the 12 months preceding Phase 3. When comparing the different aspects of mental health, current depressive symptoms had a very strong association with self-harm. Previous depressive symptoms also accounted for the relationship between self-harm in the past 12 months and previous SDQ caseness, but not the relationship between previous conduct problems and self-harm in the past 12 months.

Univariate regression indicated that, for males, SMFQ caseness at Phase 2 was associated with self-harm in the past year (OR 6.4, 95%CI 2.14-20.60, p=0.01). This association was not found for females. This finding was not explored further due to the small numbers of males who had self-harmed in the past year; however this would be interesting to explore in future research.

Most prospective associations between self-harm and mental health decreased with adjustment for current mental health. This may relate to when these issues were reported. That is, the association may relate to the temporal proximity of the assessments, not necessarily the timing of the self-harming behaviour and the psychological factors that were identified in this research. Despite these longitudinal analyses, and having assessment at two different time points, it is difficult to distinguish persistence from recurrence with these measures.

Together these results highlight the strong relationship between depressive symptoms and lifetime self-harm. There was also a noteworthy relationship between conduct problems and self-harm This, combined with the borderline SDQ results for self-harm in the past 12 months implies that more recent self-harm related to broader aspects of psychological distress as well as core depressive symptoms. These analyses present associations. It is not possible to identify a direction of causality in the relationships between mental health and self-harm from this data.

5.4. Interpersonal relationships and life events

5.4.1. Hypothesis C1: Social support

Participants reporting lower social support will be more likely to self-harm.

This hypothesis was addressed with analysis of perceived social support from friends, family and a special person. Additional analysis of the relationships between parental style and parental involvement (giving help with problems at school and encouragement to do well at school) will be included to explore different aspects of family support with respect to self-harm. All support variables were reported at Phase 3, and there was Phase 2 data on parental involvement and social support. Univariate analyses for the two self-harm categories will be presented first, followed by adjusted analysis including potential socio-demographic confounders.

5.4.1.1. Cross-sectional analyses (Phase 3)

Social Support

Table 30 presents tertiles of social support at Phase 3, assessed by the Multidimensional Scale of Perceived Social Support (MSPSS). The data were skewed towards high levels of support and were collapsed into tertiles to examine relationships between high, moderate and low support. The distribution of self-harm between the tertiles for total social support and each of the subscales in presented in Table 31.

There were clear associations between low support from family and self-harm. Participants who reported low support from family had significantly increased odds for each of the self-harm categories, with particularly strong associations for self-harm in the past 12 months (OR 4.23, 95%CI 2.16-8.30, $p<0.001$). There was no change in significance of the associations between family support and self-harm with adjustment for gender, eligibility for free school meals and ethnicity.

The mid-range tertile for social support from a special person had significantly lower odds for self-harm in the past year (OR 0.31, 95%CI 0.13-0.76, $p<0.05$). There was no alteration in this association in adjusted analysis. This result, that ‘moderate’ social support from a special person had lower odds for self-harm in the past 12 months compared with those

reporting high support may be a reflection of some of the negative impact a close relationship with a special person may have for some adolescents. It may also have been influenced by the low number of participants with moderate support from friends who had self-harmed in the past year (n=6). No other results for support from a special person were significant.

Table 30: Tertiles of perceived social support from friends, family & a special person at Phase 3

Social Support		**RELACHS Phase 3 participants**	
Phase 3 Variables	Variable categories	**N**	**%** ‡
Total Social Support	High support	276	29.4
	Moderate support	274	29.2
	Low support	283	30.1
	Missing	*106*	*11.3*
Social Support Subscales			
Support from friends	High support	277	29.5
	Moderate support	258	27.5
	Low support	298	31.7
	Missing	*106*	*11.3*
Support from a special person	High support	324	34.5
	Moderate support	196	20.9
	Low support	313	33.3
	Missing	*106*	*11.3*
Support from family	High support	359	38.2
	Moderate support	192	20.4
	Low support	282	30.0
	Missing	*106*	*11.3*
Total		**939**	**100**

‡Percentages are given by column, separately for each variable.

Table 31: Frequency and univariate odds ratios for social support at Phase 3 in association with lifetime self-harm and self-harm in the past 12 months

Exposure Variables		**Self-harm (validated)**				**Self-harm in the past 12 months**			
Phase 3 Variables	Variable categories	**N**	**%** ◊	**OR**	**95% CI**	**N**	**%** ◊	**OR**	**95% CI**
Total Social Support (Tertiles)	High support	25	9.2	1		14	5.1	1	
	Moderate support	32	12.0	1.35	0.77-2.34	20	7.3	1.47	0.73-2.98
	Low support	25	9.3	1.01	0.57-1.81	26	9.2	1.89	0.97-3.71
	Missing	*6*	*6.0*	--	--	*8*	*7.5*	--	--
Social Support Subscales									
Support from friends	High support	24	9.0	1		18	6.5	1	
	Moderate support	29	11.4	1.31	0.74-2.31	16	6.2	0.95	0.47-1.91
	Low support	29	10.2	1.15	0.65-2.03	26	8.7	1.38	0.74-2.57
	Missing	*6*	*6.0*	--	--	*8*	*7.5*	--	--
Support from a special person	High support	39	12.5	1		30	9.3	1	
	Moderate support	16	8.4	0.64	0.35-1.19	6	3.1	*0.31**	*0.13-0.76*
	Low support	27	9.0	0.69	0.41-1.16	24	7.7	0.81	0.47-1.43
	Missing	*6*	*6.0*	--	--	*8*	*7.5*	--	--
Support from family	High support	23	6.4	1		12	3.3	1	
	Moderate support	20	10.6	1.73	0.92-3.24	12	6.3	1.93	0.85-4.38
	Low support	39	15.0	**2.56****	**1.49-4.41**	36	12.8	***4.23******	***2.16-8.30***
	Missing	*6*	*6.9*	--	--	*8*	*7.5*	--	--
Total		88				68			

◊ The percentages given are by row; within each category of the exposure variable. ** p<0.05*, **** p<0.01**, ****** p<0.001***

In analysis adjusted for gender, ethnicity and eligibility for free school meals, low total social support changed from being non-significant to being significantly associated ($p<0.05$) with self-harm in the past year, (OR 2.60, 95%CI 1.31-5.18, $p< 0.01$). Entering gender into this model changed the significance of the association between social support and self-harm.

No associations between social support from friends and self-harm were significant in univariate analysis. In analysis adjusted for socio-demographic factors, the analysis of self-harm in the past 12 months became significant ($p<0.05$). For example, the odds ratio for self-harm in the preceding 12 months, in association with low support from friends changed from 1.38 (95%CI 0.74-2.57), to 1.97 (95%CI 1.03-3.76, $p<0.05$) in adjusted analysis. Entering each socio-demographic factor individually showed that it gender was the variable influencing the significance of the association between friend social support and self-harm.

All univariate analyses were tested for an interaction between social support and gender in association with self-harm. There were no significant interactions between gender and any of the social support variables, in association with self-harm in the past 12 months. For analyses of lifetime self-harm (validated), there was one significant ($p<0.05$) interaction evident between gender and Phase 3 social support from friends only when missing data for social support was included as an exposure category. This result was explored with further stratified analysis.

Gender stratified analysis was conducted on the cross-sectional model in which social support from friends was examined in association with self-harm (validated). This cross-sectional stratified analysis included 478 females, 74 of whom had self-harmed. There were significantly increased odds for self-harm in those who reported moderate or low social support from friends. That is, of the 149 girls who had moderate social support from friends, 28 (18.8%) had self-harmed and of the 114 girls who reported low social support from friends, 24 (21.1%) had also self-harmed. Unadjusted regression models indicated increased odds of self-harm (validated) for girls reporting moderate friend social support (OR 1.90, 95%CI 1.02-3.53, $p<0.05$) and also low social support from friends (OR 2.19, 95%CI 1.15-4.18, $p<0.05$). Results remained significant ($p<0.05$) with adjustment for ethnicity and eligibility for free school meals. There were no significant associations between social support from friends and self-harm (validated) in males, however, small numbers limited the analysis.

Parental involvement

Tables 32 and 33 present analysis of parental involvement data reported in Phase 3. The data was skewed, with the majority of participants reporting that their parents would "always" help them with problems at school and encourage them to do well at school. Thus the "low involvement" group was comprised of participants who did not answer "always" for both questions. There was weak evidence that participants with low parental involvement had increased odds for validated self-harm (OR 1.68, 95%CI 1.08-2.61, p<0.05) and self-harm in the past 12 months (OR 1.82, 95% CI 1.11-2.99, p<0.05). This result may relate to a specific effect for involvement, or may function as a general indicator of parental interest. There were no significant interactions between parental involvement and gender in association with self-harm. There were no changes to significance levels of the associations with adjustment for gender, eligibility for free school meals and ethnicity.

Table 32: Parental involvement reported at Phase 3

Exposure variable		**RELACHS Phase 3 participants**	
Phase 3 variable	**Variable Categories**	**N**	**% ‡**
Parental involvement	High involvement	566	60.3
	Low involvement	366	39.0
	Missing	*7*	*0.7*
Total		**939**	**100**

‡Percentages are given by column, for each variable.

Table 33: Frequency and univariate odds ratios for parental involvement at Phase 3 in association with lifetime self-harm and self-harm in the past 12 months

Exposure Variable		**Self-harm (validated)**				**Self-harm in the past 12 months**			
Phase 3 Variables	Variable categories	**N**	**% ᵉ**	**OR**	**95% CI**	**N**	**% ᵉ**	**OR**	**95% CI**
Parental involvement	High involvement	44	8.0	1		32	5.7	1	
	Low involvement	44	12.7	*1.68**	*1.08-2.61*	36	9.8	*1.82**	*1.11-2.99*
	Missing	*0*	*0*	--	--	*0*	*0*	--	--
Total									

ᵉ The percentages given are by row; percentage within each category of the exposure variable.
p<0.05*, **** p<0.01,******p<0.001***

Parental warmth & strictness

Tertiles for parental warmth and strictness reported at Phase 3 are shown in Table 34. Twenty-four participants reported that they did not have a female parent/carer and 130 participants reported that they did not have a male parent/carer. These participants have been excluded from analysis on parental style for the parent of that gender, coded as having missing data for analysis of parental warmth and strictness. As analysis was conducted separately for maternal and paternal carers, this included single parent families in the analysis.

Table 34: Tertiles of parental warmth and strictness in Phase 3

Parental style		**RELACHS Phase 3 participants**	
Phase 3 Variables	**Variable Categories**	**N**	**% ‡**
Maternal warmth	High warmth	295	31.4
	Moderate warmth	233	24.8
	Low warmth	373	39.7
	Missing♂	*38*	*4.0*
Maternal strictness	Low strictness	181	19.3
	Moderate strictness	471	50.2
	High strictness	251	26.7
	Missing♂	*36*	*3.8*
Paternal warmth	High warmth	279	29.7
	Moderate warmth	244	26.0
	Low warmth	262	27.9
	Missing♂	*154*	*16.4*
Paternal strictness	Low strictness	*180*	*32.5*
	Moderate strictness	305	32.5
	High strictness	299	31.8
	Missing♂	*155*	*16.5*
Total		**939**	**100**

‡Percentages are given by column, separately for each variable. ♂ If participants did not have a male parent/carer or female parent/carer, they were included as having missing data for these analyses as they did not answer the parental style questions.

All associations between parental warmth and self-harm were significant. Low maternal warmth had increased odds for both self-harm categories. The strongest evidence was in association with self-harm in the past 12 months (OR 3.02, 95%CI 1.52-6.00, p<0.01), followed by (validated) self-harm (OR 1.98, 95%CI 1.15-3.39, p<0.05), as shown in Table 35.

Low paternal warmth was also associated with significantly increased odds for self-harm. For paternal warmth, the strongest association was with the validated assessment of self-harm (OR 2.72, 95%CI 1.51-4.88, p<0.01) and then self-harm in the past 12 months (OR 2.45, 95%CI 1.24-4.84, p<0.05). The relationship between self-harm and parental strictness was not so clear. There was no evidence for an association between paternal strictness and self-harm. A significant association between high maternal strictness and self-harm was evident for (validated) self-harm, (OR 2.34, 95%CI 1.11-4.94, p<0.05). There was no significant association evident between parental strictness and self-harm in the past year. There were no significant interactions between gender and parental style for any self-harm category, and no change in significance level of associations with adjustment for gender, ethnicity and eligibility for free school meals.

Table 35: Frequency and univariate odds ratios for parental warmth and strictness at Phase 3 in association with lifetime self-harm and self-harm in the past 12 months

Exposure Variable		**Self-harm (validated)**				**Self-harm in the past 12 months**			
Phase 3 Variables	Variable Categories	**N**	**%** [e]	**OR**	**95% CI**	**N**	**%** [e]	**OR**	**95% CI**
Maternal warmth	High warmth	21	7.2	1		11	3.7	1	
	Moderate warmth	16	7.1	0.98	0.50-1.93	12	5.2	1.40	0.61-3.24
	Low warmth	47	13.3	*1.98*[*]	*1.15-3.39*	39	10.5	**3.02**[**]	**1.52-6.00**
	Missing	*4*	*12.1*	--	--	*6*	*15.8*	--	--
Maternal strictness	Low strictness	10	5.6	1		10	5.5	1	
	Moderate strictness	45	9.8	1.82	0.90-3.70	31	6.6	1.21	0.58-2.51
	High strictness	29	12.3	*2.34*[*]	*1.11-4.94*	24	9.6	1.81	0.84-3.88
	Missing	*4*	*11.8*	--	--	*3*	*8.3*	--	--
Paternal warmth	High warmth	18	6.5	1		13	4.7	1	
	Moderate warmth	15	6.4	0.98	0.48-1.99	15	6.1	1.34	0.63-2.87
	Low warmth	40	16.0	**2.72**[**]	**1.51-4.88**	28	10.7	*2.45*[*]	*1.24-4.84*
	Missing	*15*	*10.3*	--	--	*12*	*7.8*	--	--
Paternal strictness	Low strictness	20	11.5	1		13	7.2	1	
	Moderate strictness	28	9.4	0.80	0.44-1.47	21	6.9	0.95	0.46-1.95
	High strictness	27	9.4	0.80	0.43-1.47	23	7.7	1.07	0.53-2.17
	Missing	*13*	*8.8*	--	--	*11*	*7.1*	--	--

[e] The percentages given are by row; percentage within each category of the exposure variable.
** p<0.05*, *** p<0.01**, *****p<0.001***

5.4.1.2. Longitudinal analyses (Phases 2 & 3)

Social support

Table 36 presents tertiles of social support reported in Phase 2. Table 37 shows the results from univariate regression analyses with Phase 2 social support in association with self-harm in the year preceding Phase 3. Regression analyses were not conducted using family social support as there were only four participants in the reference group reporting both self-harm and high social support from family. There was no significant associations between social support from Phase 2 and self-harm in the past 12 months.

Parental involvement

Analysis of parental involvement reported at Phase 2 is shown in Tables 38 and 39. There were no significant associations between parental involvement reported at Phase 2 and self-harm, with or without adjustment for gender, eligibility for free school meals and ethnicity. There were no significant interactions between parental involvement and gender.

Table 36: Prevalence of perceived social support from friends, family & a special person in Phase 2

Social Support		**RELACHS Phase 3 participants**	
Phase 2 variables	**Variable Categories**	**N**	**%** ‡
Total Social Support (Tertiles)	High support	203	25.2
	Moderate support	206	25.5
	Low support	211	26.1
	Missing	*187*	*23.2*
Social Support Subscales			
Support from friends	High support	224	27.8
	Moderate support	170	21.1
	Low support	226	28.0
	Missing	*187*	*23.2*
Support from a special person	High support	193	23.9
	Moderate support	193	23.9
	Low support	234	19.0
	Missing	*187*	*23.2*
Support from family	High support	171	21.2
	Moderate support	188	23.2
	Low support	261	32.2
	Missing	*187*	*23.2*
Total		**807**	**100**

‡Percentages are given by column, separately for each variable.

Table 37: Frequency and univariate odds ratios for social support at Phase 2 in association with self-harm in the past 12 months

Exposure Variables		**Self-harm in the past 12 months**			
Phase 2 exposures	Variable categories	**N**	**%**[e]	**OR**	**95% CI**
Total Social Support (Tertiles)	High support	13	6.4	1	
	Moderate support	18	8.7	1.40	0.67-2.94
	Low support	16	7.6	1.20	0.56-2.56
	Missing	*11*	*5.9*	--	--
Social Support Subscales					
Support from friends	High support	15	6.7	1	
	Moderate support	15	8.8	1.35	0.64-2.84
	Low support	17	7.5	1.13	0.55-2.33
	Missing	*11*	*5.9*	--	--
Support from a special person	High support	19	9.8	1	
	Moderate support	16	8.3	0.83	0.41-1.66
	Low support	12	5.1	0.50	0.23-1.05
	Missing	*11*	*5.9*	--	--
Support from family	High support	4	2.3	--[§]	--[§]
	Moderate support	19	10.1	--	--
	Low support	24	9.2	--	--
	Missing	*11*	*5.9*	--	--
Total		58			

[e] The percentages given are by row; percentage within each category of the exposure variable.
* *p<0.05,* **** p<0.01**, ***** *p<0.001*** [§] Regression analysis not conducted due to limited numbers in the reference group.

Table 38: Parental involvement reported at Phase 2

Exposure variable		**RELACHS Phase 3 participants**	
Phase 2 variable	Variable Categories	**N**	**% ‡**
Parental involvement	High involvement	527	65.3
	Low involvement	262	32.5
	Missing	*18*	*2.2*
Total		807	

‡Percentages are given by column, for each variable.

Table 39: Frequencies and univariate odds ratios for parental involvement at Phase 2 in association with self-harm in the past 12 months

Exposure Variable		**Self-harm in the past 12 months**			
Phase 2 variable	Variable Categories	**N**	**% ɵ**	**OR**	**95% CI**
Parental involvement	High involvement	36	6.8	1	
	Low involvement	22	8.4	1.25	0.72-2.17
	Missing	*0*	*0*	--	--
Total		58			

ɵ The percentages given are by row; within each category of the exposure variable. ** p<0.05*, **** p<0.01**, ****** p<0.001***

5.4.1.3. Summary of univariate associations with self-harm

Significant univariate results for hypothesis C1 are summarised below, reporting associations with self-harm (validated) and self-harm in the past year. Following the summary are results from adjusted analysis addressing relative contributions of different exposures variables.

Cross-sectional univariate analysis showed significantly increased odds for low family support, low parental involvement, high maternal strictness and low maternal and paternal warmth, in association with the self-harm (validated) category. In analysis of self-harm in the past year, cross-sectional models showed univariate associations with low social support from family, low parental involvement and low warmth in parental style from both maternal and paternal carers. There was also an association between moderate social support from a special person, which reduced the odds for self-harm in the past twelve months. Longitudinal analysis showed no significant associations between social support and self-harm in the past twelve months. As there were no significant longitudinal associations, no further analyses were conducted to examine the relative contribution of variables from Phases 2 and 3.

5.4.1.4. Adjusted analyses (Phase 3)

To explore different aspects of parental style, assessments which had significant univariate associations with self-harm were entered into multivariate models. Table 40 presents the adjusted odds ratios for self-harm (validated) and self-harm in the past 12 months for paternal warmth, maternal warmth and maternal strictness, with two parental style exposures entered in each model shown in the table (Models A-C). Only two assessments were entered into each model to enable direct comparisons between the each of the different assessments.

Models A and C in Table 40 show that parental warmth and maternal strictness both remained significant in analysis for self-harm (validated). The warmth variables accounted for the association between maternal strictness and self-harm in the past year. Maternal and paternal warmth became non-significant when both entered into Model B, for validated self-harm, however, there was still a significant association between low maternal warmth and self-harm in the past 12 months (OR 2.64, 95%CI 1.24-5.65, $p<0.05$). There were no significant interactions between parental warmth and strictness in these analyses for either self-harm category. A final adjusted model was run, including all three parental style variables. High maternal strictness had increased odds for (validated) self-harm (OR 2.63, 95%CI 1.22-5.70, $p<0.05$) and low maternal warmth was assessed with self-harm in the past twelve months (OR 2.55, 95%CI 1.18-5.50, $p<0.05$). There were no other significant associations between self-harm and parental style in these adjusted models.

Further cross-sectional analysis examined relationships between the assessments of family support, parental style and involvement. There were no significant interactions between any of the family support and parental style variables in association with self-harm.

In models testing for independent effects, only two assessments entered into each model (D-J in Table 41) to unpack the relationships between each pair of assessments. Parental involvement was accounted for by parental warmth and social support, but not maternal strictness. Maternal strictness retained a significant independent association with self-harm (validated) when adjusted for parental involvement and family social support. There was strong evidence for low social support from family increasing odds of self-harm, even when accounting for parental style and involvement. Family support accounted for the association between parental warmth and self-harm. Parental warmth and family support

related to both self-harm categories, strictness only remained associated with the lifetime assessment of self-harm (validated) in adjusted analyses, not self-harm in the preceding 12 months. Together these results imply that the influence of family warmth, support and involvement are all protective against self-harm, and the construct they may represent differs from the assessment of parental strictness.

Table 40: Adjusted cross-sectional odds ratios for Phase 3 parental style in association with self-harm (validated) and in the past 12 months.

Phase 3 Variables‡			**Self-harm (validated)** ***N=905***	**Self-harm in past 12 months** ***N=939***
			Adjusted∂ OR (95%CI)	**Adjusted∂ OR (95%CI)**
Model A	**Maternal warmth**	High warmth	1	1
		Moderate warmth	1.01 (0.51-2.02)	1.40 (0.60-3.25)
		Low warmth	*1.83 (1.05-3.18)* *	**2.78 (1.39-5.58)****
	Maternal strictness	Low strictness	1	1
		Moderate strictness	1.82 (0.88-3.74)	1.15 (0.54-2.43)
		High strictness	*2.48 (1.16-5.35)* *	1.68 (0.77-3.69)
Model B	**Maternal warmth**	High warmth	1	1
		Moderate warmth	0.93 (0.46-1.87)	1.36 (0.58-3.17)
		Low warmth	1.49 (0.81-2.77)	*2.64 (1.24-5.65)* *
	Paternal warmth	High warmth	1	1
		Moderate warmth	0.83 (0.39-1.75)	0.94 (0.42-2.11)
		Low warmth	1.83 (0.93-3.58)	1.31 (0.60-2.83)
Model C	**Maternal strictness**	Low strictness	1	1
		Moderate strictness	1.87 (0.91-3.87)	1.15 (0.55-2.43)
		High strictness	**2.77 (1.29-5.98)****	1.91 (0.88-4.15)
	Paternal warmth	High warmth	1	1
		Moderate warmth	0.90 (0.44-1.86)	1.25 (0.58-2.70)
		Low warmth	***2.30 (1.26-4.19)*** **	*2.12 (1.06-4.22)**

‡ Only assessments with significant univariate results from univariate analysis have been included. ∂ Adjusted for gender, eligibility for free school meals and ethnicity, separate models run for each comparison * *p<0.05,* ** **p<0.01,** *** ***p<0.001***

Table 41: Adjusted cross-sectional odds ratios for Phase 3 family social support, parental style and involvement in association with self-harm (validated) and self-harm in the past 12 months

Phase 3 Variables‡		**Self-harm (validated) N=905**	**Self-harm in past 12 months N=939**
		Adjusted∂ OR (95%CI)	**Adjusted∂ OR (95%CI)**
Model D			
Parental involvement	High involvement	1	1
	Low involvement	1.11 (0.66-1.87)	0.99 (0.56-1.77)
Family social support	High social support	1	1
	Moderate social support	1.70 (0.88-3.28)	1.95 (0.84-4.51)
	Low social support	**2.59 (1.37-4.90)****	***4.57 (2.12-9.83)******
Model E			
Parental involvement	High involvement	1	1
	Low involvement	1.32 (0.79-2.21)	1.24 (0.71-2.16)
Maternal warmth	High warmth	1	1
	Moderate warmth	0.93 (0.46-1.87)	1.32 (0.56-3.10)
	Low warmth	1.63 (0.88-3.04)	*2.60 (1.21-5.55)**
Model F			
Parental involvement	High involvement	1	1
	Low involvement	*1.65 (1.03-2.56)**	*1.79 (1.08-2.96)**
Maternal strictness	Low strictness	1	1
	Moderate strictness	1.82 (0.89-3.75)	1.14 (0.54-2.39)
	High strictness	*2.67 (1.24-5.72)**	1.89 (0.87-4.10)
Model G			
Parental involvement	High involvement	1	1
	Low involvement	1.31 (0.80-2.15)	1.53 (0.89-2.64)
Paternal warmth	High warmth	1	1
	Moderate warmth	0.89 (0.43-1.84)	1.18 (0.54-2.57)
	Low warmth	*2.02 (1.06-3.88)**	1.73 (0.82-3.64)
Model H			
Family social support	High social support	1	1
	Moderate social support	1.68 (0.84-3.35)	1.70 (0.71-4.07)
	Low social support	*2.46 (1.25-4.85)**	**3.54 (1.60-7.82)****
Maternal warmth	High warmth	1	1
	Moderate warmth	0.85 (0.42-1.72)	1.17 (0.49-2.77)
	Low warmth	1.15 (0.59-2.25)	1.57 (0.70-3.49)
Model I			
Family social support	High social support	1	1
	Moderate social support	1.72 (0.91-3.28)	1.93 (0.84-4.43)
	Low social support	**2.63 (1.50-4.62)**¤**	***4.33 (2.18-8.60)******
Maternal strictness	Low strictness	1	1
	Moderate strictness	1.82 (0.88-3.76)	1.10 (0.52-2.34)
	High strictness	*2.44 (1.13-5.27)**	1.59 (0.73-3.49)
Model J			
Family social support	High social support	1	1
	Moderate social support	1.56 (0.80-3.05)	1.84 (0.78-4.32)
	Low social support	*2.23 (1.21-4.11)**	***4.19 (2.01-8.73)******
Paternal warmth	High warmth	1	1
	Moderate warmth	0.80 (0.38-1.67)	1.04 (0.47-2.32)
	Low warmth	1.62 (0.84-3.13)	1.23 (0.58-2.60)

‡ Only assessments with significant univariate results from univariate analysis have been included. ∂ Adjusted for gender, eligibility for free school meals and ethnicity, separate models run for each comparison * *p<0.05,* ** **p<0.01,** *** ***p<0.001***

5.4.2. Hypothesis C2: Bullying

Young people who have been victims of bullying will be more likely to self-harm.

5.4.2.1. Cross-sectional analyses (Phase 3)

This hypothesis will be addressed with analysis of lifetime bullying reported at Phase 2 and Phase 3, shown in Tables 42-43. From cross-sectional analysis, with lifetime bullying reported at Phase 3 as the main exposure variable, “ever having been bullied” was associated with a more than two-fold increase in the risk of lifetime self-harm. There was no significant association between ever having been bullied and self-harm in the past 12 months. There were no significant interactions between bullying reported at Phase 3 and gender in relation to self-harm, and no changes in the significance in relationships between bullying and self-harm in analysis adjusted for gender, eligibility for free school meals and ethnicity.

Table 42: Lifetime experience of bullying in Phase 3

Phase 3 exposure variable		**RELACHS Phase 3 participants**	
	Variable Categories	**N**	**% ‡**
Lifetime experience of bullying	Never been bullied	623	66.3
	Bullied	284	30.2
	Missing	*32*	*3.4*
Total		**939**	**100**

‡Percentages are given by column, for each variable.

Table 43: Frequency and univariate odds ratios for lifetime experience of bullying reported at Phase 3 in association with lifetime self-harm and self-harm in the past 12 months

Exposure Variable		**Self-harm (validated)**				**Self-harm in the past 12 months**			
Phase 3 variable		**N**	**% [e]**	**OR**	**95% CI**	**N**	**%**	**OR**	**95% CI**
Lifetime experience of bullying	Never been bullied	45	7.4	1		38	6.1	1	
	Bullied	39	14.6	**2.13****	**1.35-3.36**	27	9.5	1.62	0.97-2.71
	Missing	*4*	*12.5*	--	--	*3*	*9.4*	--	--
		88				68			

[e] The percentages given are by row; percentage within each category of the exposure variable.
* p<0.05, **** p<0.01**, ****** p<0.001***

5.4.2.2. Longitudinal analyses (Phases 2 & 3)

The lifetime assessment of bullying reported at Phase 2 (Table 44) was examined in relation to self-harm in the year preceding Phase 3. There was a weak, but significant association between bullying reported at Phase 2 and self-harm in the 12 months prior to Phase 3 ($p<0.05$), see Table 45. There were no significant interactions between bullying reported at Phase 2 and gender when in association with self-harm. Adjustment for

gender, ethnicity and eligibility for free school meals had little impact on the associations between bullying reported at Phase 2 and self-harm.

Table 44: Lifetime experience of bullying in Phase 2

Phase 2 exposure variable		**RELACHS Phase 3 participants**	
	Variable Categories	**N**	**%**
Lifetime experience of bullying	Never been bullied	539	66.8
	Bullied	199	24.7
	Missing	*69*	*8.6*
Total		**807**	**100**

Table 45: Frequency and univariate odds ratios for lifetime experience of bullying reported at Phase 2 in association with self-harm in the past 12 months

Exposure Variable		**Self-harm in the past 12 months**			
Phase 2 variable		**N**	**%**	**OR**	**95% CI**
Phase 2 Lifetime bullying	Never been bullied	32	5.9	1	
	Bullied	22	11.1	*1.97*[*]	*1.12-3.48*
	Missing	*4*	*5.8*	--	--
		58			

[e] The percentages given are by row; percentage within each category of the exposure variable.
** p<0.05*, **** p<0.01**, ****¤ p=0.001, *** *p<0.001***

5.4.3. Hypothesis C3: Adverse life events

Participants reporting more adverse life events in the past year will be more likely to self-harm than those who have experienced fewer life events.

5.4.3.1. Cross-sectional analyses (Phase 3)

Adverse life events were reported at Phase 3 only, assessing both emotional and material deprivation. The prevalence of each event and the summary variable for life events are presented in Table 46. Frequent parental arguments were reported by just under half of the sample. Over a quarter of the sample reported parental divorce or separation, that their parents or carers had a serious health problem, and that someone in their family had experienced a mugging or burglary. The median number of life events was two.

Table 46: Prevalence of life events reported in Phase 3

Phase 3 Variables		RELACHS Phase 3 participants	
Adverse life events		**N**	**% ǂ**
Your parents often fought or argued		467	49.7
You were in care/ foster home / children's home		17	1.8
Your family had continuing money problems		212	22.6
Your mum, dad, sister or brother died		102	10.9
Your parents were divorced or separated		248	26.4
Your parents/ carers had a severe illness, injury or operation		268	28.5
Your family experienced a mugging, robbery or burglary		305	32.5
Your parents/carers drank alcohol it caused family problems		63	6.7
Sum of adverse life events	No adverse life events	208	22.2
	1 adverse life event	218	23.2
	2 adverse life events	221	23.5
	>=3 events	279	29.7
	missing	*13*	*1.4*
Total		**939**	**100**

ǂPercentages are given by row, for each life event.

Table 47 shows the relationships between life events and self-harm. For lifetime self-harm (validated), there was a dose-response effect with increasing prevalence and odds for self-harm with each increase in the number of life events. For example, participants reporting two adverse life events had an odds ratio of 3.11 (95%CI 1.29-7.48, $p<0.05$) for self-harm (validated), in comparison with the group who reported three or more adverse life events (OR 6.03, 95%CI 2.66-13.66, $p<0.001$). Analysis of self-harm in the past 12 months was not conducted due to the small number of participants in the reference group. There were no interactions between gender and life events, irrespective of whether the missing values were included as a category or coded as missing. There were no changes in the significance of associations between life events and self-harm in analysis adjusted for gender, ethnic group and eligibility for free school meals. Adverse life events were not collected in Phase 2, thus there was no data to examine longitudinal associations.

5.4.4. Adjusted analyses combining hypotheses C1, C2 & C3

5.4.4.1. Adjusted cross-sectional analyses (Phase 3)

To collate the results from the hypotheses in this section, significant univariate results were combined into multivariate models. Due to limited numbers, multivariate analysis for self-harm in the past 12 months only included cross-sectional exposures (family social support and lifetime bullying). Cross-sectional analysis of associations with self-harm (validated) was more comprehensive, including Phase 3 family social support, bullying and

life events. In adjusted cross-sectional analysis, shown in Table 48, participants reporting low social support from family, lifetime experience of bullying and more than two adverse life events all showed increased risk for lifetime self-harm (validated). In contrast, the analysis of associations with self-harm in the past 12 months showed that adjustment for family social support accounted for the relationship between ever having been bullied and self-harm in the past year. Low family support reported at Phase 3 retained a significant association with self-harm in the past year (OR 4.56, 95%CI 2.30-9.06, p<0.001).

5.4.4.2. Adjusted longitudinal analyses (Phases 2 & 3)

No further longitudinal analyses were conducted for this section as there only bullying at Phase 2 showed a significant association with self-harm in the 12 months prior to Phase 3, and thus there were no other significant factors relating to interpersonal relationships to add to the model.

Table 47: Frequencies and univariate odds ratios for adverse life events reported at Phase 3 in association with lifetime and 12 month prevalence of self-harm

Exposure Variable		**Self-harm (validated)**				**Self-harm in the past 12 months**			
		N	**%[e]**	**OR**	**95% CI**	**N**	**%[e]**	**OR**	**95% CI**
Adverse life events	No adverse life events	7	3.4	1		3	1.4	--[§]	--[§]
	1 adverse life event 1	13	6.2	1.87	0.73-4.78	14	6.4	--	--
	2 adverse life events 2	21	9.9	*3.11*[*]	*1.29-7.48*	14	6.3	--	--
	>=3 events 3	46	17.5	***6.03***[***]	***2.66-13.66***	35	12.5	--	--
	missing	*1*	*8.3*	*1.31*	*0.17-10.37*	*2*	*15.4*	--	--
		88				68			

[e] The percentages given are by row; percentage within each category of the exposure variable. [§] Regression analysis not conducted due to limited numbers in the reference group for this model. * *p<0.05*, **** p<0.01**, ***** *p<0.001***

Table 48: Frequency and adjusted odds ratios for significant univariate Phase 3 associations with lifetime self-harm (validated) and self-harm in the past 12 months

Exposure Variables		**Self-harm (validated)**				**Self-harm in the past 12 months**			
Phase 3 exposures	Variable categories	**N**	**%[e]**	**OR**	**95% CI**	**N**	**%[e]**	**OR**	**95% CI**
Support from family	High support	23	6.4	1		12	3.3	1	
	Moderate support	20	10.6	1.63	0.85-3.12	12	6.3	1.95	0.85-4.46
	Low support	39	15.0	**2.34**[**]	**1.32-4.16**	36	12.8	***4.56***[***]	***2.30-9.06***
	Missing	*6*	*6.9*	--	--	*8*	*7.5*	--	--
Lifetime experience of bullying	Never been bullied	45	7.4	1		38	6.1	1	
	Bullied	39	14.6	*1.85*[*]	*1.14-2.99*	27	9.5	1.59	0.93-2.70
	Missing	*4*	*12.5*	--	--	*3*	*9.4*	--	--
Adverse life events	No adverse life events	7	3.4	1		--		--	
	1 adverse life event 1	13	6.2	1.76	0.68-4.59	--		--	
	2 adverse life events 2	21	9.9	*2.49*[*]	*1.02-6.11*	--		--	
	>=3 events 3	46	17.5	**4.41**[**¤]	**1.90-10.22**	--		--	
	Missing	*1*	*8.3*	--	--			--	--
Total		88				68			

[e] The percentages given are by row; percentage within each category of the exposure variable.
* *p<0.05,* **** p<0.01**, [**¤] ***p*=0.001, *** *p<0.001***

5.4.5. Summary of key findings for section 5.4.

Hypothesis C1: Social support and parental style

Cross-sectional analyses illustrate a strong relationship between low social support from family and increased risk of self-harm. Social support from other sources did not have such consistent associations with self-harm, emphasising the importance of family support for young people. Cross-sectional analyses showed that low and moderate social support from friends was associated with increased odds for self-harm in females, but not males. The results relating to support from family are supported by the associations between parental style and self-harm, with low warmth and high maternal strictness being associated with self-harm. Lack of support and warmth from parents were associated with both lifetime self-harm and self-harm in the past twelve months. Maternal strictness was associated with self-harm (validated), but not self-harm in the preceding year. As the validated assessment refers to lifetime self-harm, this result may imply a relationship between maternal strictness and self-harm at an earlier age.

Hypothesis C2: Bullying

Lifetime experience of bullying, as reported at Phase 3 was associated with lifetime self-harm, but not self-harm in the past 12 months. Ever having been bullied at Phase 2 was associated with increased odds for self-harm in the past 12 months. As variables in this analysis included lifetime assessments, it is difficult to interpret these associations.

Hypothesis C3: Life events

With a median of two adverse life events, and just under one third of the participants reporting three or more life events, this sample showed high levels of emotional and material deprivation. A greater number of life events were associated with higher risk of lifetime self-harm.

5.4.5.1. Adjusted analyses combining hypotheses C1, C2 & C3

Multivariate analyses were conducted to assess the associations of each of the variables which had significant univariate associations with self-harm. Cross-sectional analyses demonstrated that adjustment for family social support accounted for the association between lifetime experiences of bullying and self-harm in the past year. The independent associations between self-harm (validated) and Phase 3 family social support, lifetime bullying and adverse life events remained significant in adjusted analysis.

5.5. Cultural factors and identity

5.5.1. Hypothesis D1: Acculturation

Young people with marginalised and assimilated acculturative styles will have an increased likelihood of self-harm compared with those reporting integrated cultural identity, in accordance with Berry's model of acculturation (Berry 1980).

5.5.1.1. Cross-sectional analyses (Phase 3)

The hypotheses for cultural identity and social stressors were proposed based on previous research relating culture with mental health and self-harm. This analysis is further justified given the findings from this study, which showed a higher prevalence of self-harm in Asian British participants.

The domains of friendship and clothing choices have been examined according to Berry's model, identifying four acculturative styles (See Figure 2 in section 2.9.2.2.). Integrated acculturative style refers to people who reported high identification with both their own and other ethnic groups. The traditional group, sometimes referred to as "separated", reported high identification with their own ethnic group and low identification with other ethnic groups. The assimilated group reported low identification with their own ethnic group and high identification with other groups, while the marginalised category is constituted of participants who reported low identification with both their own and other ethnic group in relation to clothing and friendship choices. The "integrated" group are assumed to have the most adaptive acculturative style, and were thus used as the reference group for regression analyses.

Table 49 presents the prevalence of acculturative styles reported for friendship and clothing choices at Phase 3. Regarding friendship, a smaller proportion of young people reported "marginalised" friendship choices at school compared with other acculturative styles. Outside of school, assimilated and marginalised were less common than integrated and traditional choices. In contrast, "marginalised" clothing choices were most frequently reported compared with other styles. Integrated clothing choices were reported the least frequently both with friends and family.

Table 50 presents the results for analysis of acculturative style for friendship choices at Phase 3 in relation to self-harm. There were no associations between friendship choices at Phase 3 and self-harm either before or after adjustment for gender, ethnicity and eligibility for free school meals. There were no significant interactions between gender and Phase 3 friendship choices in association with self-harm.

There were no significant univariate relationships between clothing cultural identity reported at Phase 3 and self-harm, as shown in Table 51. There was no change in the associations between clothing choices with family and self-harm in the preceding year or self-harm (validated) with adjustment for gender, eligibility for free school meals and ethnicity, nor any interaction between clothing choice and gender.

Table 49: Prevalence of acculturative style categories for friendship and clothing choices at Phase 3

Cultural identity assessments		**RELACHS Phase 3 participants**	
Phase 3 Variables	**Variable Categories**	**N**	**%** ‡
Friendship choices within school	Integrated	334	35.6
	Traditional	291	31.0
	Assimilated	207	22.0
	Marginalised	87	9.3
	Missing	*20*	*2.1*
Friendship choices outside school	Integrated	275	29.3
	Traditional	378	40.3
	Assimilated	110	11.7
	Marginalised	130	13.8
	Missing	*46*	*4.9*
Clothing choices with friends outside school	Integrated	118	12.6
	Traditional	210	22.4
	Assimilated	143	15.2
	Marginalised	424	45.2
	Missing	*44*	*4.7*
Clothing choices with family	Integrated	117	12.5
	Traditional	232	24.7
	Assimilated	111	11.8
	Marginalised	418	45.6
	Missing	*51*	*5.4*
Total		**939**	**100**

‡Percentages are given by column, for each variable.

Table 50: Frequencies and univariate odds ratios for cultural identity of friendship choices at Phase 3 in association with lifetime self-harm and self-harm in the past 12 months

Exposure Variables		**Self-harm (validated) *N=905***				**Self-harm in past 12 months *N=939***			
Phase 3 exposures		**N**	**%**[e]	**OR**	**95% CI**	**N**	**%**[e]	**OR**	**95% CI**
Friendship choices within school	Integrated	36	11.3	1		21	6.3	1	
	Traditional	22	7.8	0.67	0.38-1.16	22	7.6	1.22	0.66-2.27
	Assimilated	23	11.4	1.02	0.59-1.78	18	8.7	1.42	0.74-2.73
	Marginalised	6	7.3	0.62	0.25-1.53	6	6.9	1.10	0.43-2.83
	Missing	*1*	*5.3*	--	--	*1*	*5.0*	--	--
Friendship choices outside school	Integrated	22	8.4	1		16	5.8	1	
	Traditional	38	10.3	1.26	0.72-2.18	31	8.2	1.45	0.78-2.70
	Assimilated	14	13.2	1.66	0.82-3.38	11	10.0	1.80	0.81-4.01
	Marginalised	12	9.8	1.18	0.56-2.47	10	7.7	1.35	0.60-3.06
	Missing	*2*	*4.3*	--	--	*0*	*0*	--	--
Total		88	9.7%			68			

[e] The percentages given are by row; separately within each category of the exposure variable.* *p<0.05*, **** p<0.01**,******p<0.001***

Table 51: Frequencies and univariate odds ratios for cultural clothing choices at Phase 3 in association with lifetime self-harm and self-harm in the past 12 months

Exposure Variables		**Self-harm (validated) *N=905***				**Self-harm in past 12 months *N=939***			
Phase 3 exposures		**N**	**%**[e]	**OR**	**95% CI**	**N**	**%**[e]	**OR**	**95% CI**
Clothing choices with friends	Integrated	13	11.6	1		7	5.9	1	
	Traditional	18	8.7	0.73	0.34-1.55	12	5.7	0.96	0.37-2.51
	Assimilated	15	11.0	0.94	0.43-2.08	14	9.8	1.72	0.67-4.42
	Marginalised	42	10.2	0.87	0.45-1.68	32	7.5	1.29	0.56-3.01
	Missing	*0*	*0*	--	--	*3*	*6.8*	--	--
Clothing choices with family	Integrated	14	12.6	1		9	7.7	1	
	Traditional	19	8.4	0.64	0.31-1.33	15	6.5	0.83	0.35-1.96
	Assimilated	10	9.4	0.72	0.31-1.70	8	7.2	0.93	0.35-2.51
	Marginalised	45	10.9	0.85	0.45-1.61	35	8.2	1.07	0.50-2.29
	Missing	*0*	*0*	--	--	*1*	*2.0*	--	--
Total		88	9.7			68	7.2		

[e] The percentages given are by row; percentage within each category of the exposure variable.* *p<0.05*, **** p<0.01**, ****** 0.001***

5.5.1.2. Longitudinal analyses (Phases 2 & 3)

Table 52 shows the prevalence of different acculturative styles across friendship and clothing choices at Phase 2. The distribution is similar to that in Phase 3, with lower frequencies of marginalised friendship choices within school and marginalised and assimilated friendship choices outside of school. Marginalised clothing choices were the most frequently reported in both contexts, with both friends and family.

Table 52: Prevalence of acculturative style categories for friendship and clothing choices at Phase 2

Cultural identity assessments		**RELACHS Phase 2 participants**	
Phase 2 Variables	**Variable Categories**	**N**	**%‡**
Friendship choices within school	Integrated	280	34.7
	Traditional	232	28.7
	Assimilated	198	24.5
	Marginalised	80	9.9
	Missing	*17*	*2.1*
Friendship choices outside school	Integrated	227	28.1
	Traditional	303	37.5
	Assimilated	108	13.4
	Marginalised	138	17.1
	Missing	*31*	*3.8*
Clothing choices with friends	Integrated	124	15.4
	Traditional	183	22.7
	Assimilated	150	18.6
	Marginalised	304	37.7
	Missing	*46*	*5.7*
Clothing choices with family	Integrated	117	14.5
	Traditional	193	23.9
	Assimilated	125	15.5
	Marginalised	321	39.8
	Missing	*51*	*6.3*
Total		**807**	**100**

‡Percentages are given by column, for each variable.

Table 53 presents the frequencies and univariate regression analyses for Phase 2 friendship choices and self-harm. There was an association between self-harm in the past year and assimilated friendship choices. The odds for self-harm in the last 12 months were significantly higher for participants reporting assimilated friendship choices at school, that is people whose school friends were more likely to be from ethnic groups other than their own (OR 2.14, 95%CI 1.05-4.34, $p<0.05$). This association remained significant with adjustment for socio-demographic factors, with the odds ratio of self-harm in the past year being 2.16 (95%CI 1.04-4.48, $p<0.05$) for participants with assimilated friendship choices in school, compared with integrated friendship choices. There were no other significant associations between acculturative style and friendship choices from Phase 2 in univariate or adjusted analyses. There were no significant interactions between gender and any of the friendship choice data in association with self-harm.

Results for clothing choices in Phase 2 are presented in Table 54. There were no significant associations between clothing choice with friends and the self-harm. There were no interactions between gender and clothing choices with friends for self-harm.

Table 53: Frequencies and univariate odds ratios of acculturative style for friendship choices at Phase 2 in association with self-harm in the past 12 months

Exposure Variables		**Self-harm in past 12 months *N=807***			
Phase 2 exposures		**N**	**%[e]**	**OR**	**95% CI**
Friendship choices within school	Integrated	14	5.0	1	
	Traditional	19	8.2	1.70	0.83-3.46
	Assimilated	20	10.1	*2.14*[*]	*1.05-4.34*
	Marginalised	4	5.0	1.00	0.32-3.13
	Missing	*1*	*5.9*	--	--
Friendship choices outside school	Integrated	15	6.6	1	
	Traditional	22	7.3	1.11	0.56-2.18
	Assimilated	9	8.3	1.29	0.54-3.04
	Marginalised	8	5.8	0.87	0.36-2.11
	Missing	*4*	*12.9*	--	--
Total		58	7.2		

[e] The percentages given are by row; separately within each category of the exposure variable.
* *p<0.05*, **** p<0.01**, ***** *p<0.001***

Table 54: Frequencies and univariate odds ratios for acculturative style of clothing choices at Phase 2 in association with self-harm in the past 12 months

Exposure Variables		**Self-harm in past 12 months *N=807***			
Phase 2 exposures		**N**	**%[e]**	**OR**	**95% CI**
Clothing choices with friends	Integrated	7	5.6	1	
	Traditional	10	5.5	0.97	0.36-2.61
	Assimilated	12	8.0	1.45	0.55-3.81
	Marginalised	25	8.2	1.50	0.63-3.56
	Missing	*4*	*8.7*	--	--
Clothing choices with family	Integrated	1	0.9	[§]	[§]
	Traditional	15	7.8	--	--
	Assimilated	12	9.6	--	--
	Marginalised	24	7.5	--	--
	Missing	*6*	*11.8*	--	--
Total		58			

[e] The percentages given are by row; separately within each category of the exposure variable.
* *p<0.05*, **** p<0.01**, ***** *p<0.001*** [§] Regression analysis not conducted due to limited numbers in the reference group.

5.5.2. Summary of key findings for section 5.5.

There was some evidence supporting hypothesis D1, with assimilated friendship choices in school at Phase 2 showing increased odds for self-harm in the preceding twelve months. This illustrates some increase in risk for those with assimilated acculturative styles, that is, a stronger identification with other cultures and lower identification with their own culture. This support for the hypothesis should be treated with caution as the analysis showed no significant associations between marginalised acculturative style and self-harm. Additionally, there were no significant associations between self-harm and cultural identity questions from Phase 3.

5.6. Summary of quantitative study results

Each of the preceding results sections (5.2-5.5) included a summary of the results addressing each hypothesis. Table 55 shows a list of exposures from regression models which had associations (significant to $p<0.05$) with self-harm in the preceding 12 months (derived from the self-harm Y/N assessment) and lifetime self-harm (meeting the study validation criteria). These results will be discussed in Chapter 9.

Table 55: List of factors associated with self-harm (validated) and self-harm in the 12 months prior to Phase 3 in longitudinal and cross-sectional univariate regression analysis.

Significant univariate associations with lifetime self-harm (validated)	
Phase 3 factors	Gender Not living in an overcrowded home Psychological distress (SDQ total caseness) Conduct problems (SDQ subscale) Emotional problems (SDQ subscale) Depressive symptoms (SMFQ subscale) Social support from family Parental involvement Maternal warmth Paternal warmth Maternal strictness Ever been bullied Adverse life events
Significant univariate associations with self-harm in the past 12 months	
Phase 3 factors	Gender Asian British (ethnic group) Psychological distress (SDQ total caseness) Conduct problems (SDQ subscale) Emotional problems (SDQ subscale) Depressive symptoms (SMFQ subscale) Social support from family Parental involvement Maternal warmth Paternal warmth Maternal strictness
Phase 2 factors	Conduct problems (SDQ subscale) Emotional problems (SDQ subscale) Depressive symptoms (SMFQ subscale) Ever been bullied Choice of friends at school, relating to cultural identity

6. Feasibility Pilot study

6.1. Introduction

This chapter presents the methods and results for a feasibility study, conducted prior to the main qualitative study in this doctoral thesis, reported in Chapters 6 and 7. To ascertain whether a qualitative school-based study exploring self-harm was feasible, a pilot study was conducted to assess both content and methodology. The pilot was conducted soon after the quantitative data collection for RELACHS Phase 3 (August- September 2005), with the support of liaison contacts from participating secondary schools. Practical limitations were placed on the study design and implementation as piloting coincided with participants finishing year 11 and leaving school.

6.2. Aims

The aims of the pilot study were:

i) To assess the feasibility of conducting follow-up interviews with young people who reported self-harm in an earlier school-based survey.

ii) To assess mental health and coping strategies in young people who had and had not self-harmed.

iii) To briefly explore the experience of starting to self-harm and assess the feasibility of conducting further in-depth interviews on this topic.

6.3. Methods

6.3.1. Participants

Two groups of year 11 girls who had participated in RELACHS Phase 3 were invited for individual interviews to discuss health, coping and well-being. The groups were defined by self-harm status; those who had self-harmed in the past year and those who had not, based on the self-report questions from RELACHS Phase 3. The selection process is outlined below.

6.3.1.1. Young people who had self-harmed

Pupils from 20 schools were invited. Of the seven RELACHS schools that did not participate in this sub-study, four were all boys' schools, one school did not have any participants who reported self-harm and two schools had not yet participated in RELACHS at the time of sample selection.

All female participants of RELACHS Phase 3 (aged 15-16 years) who reported self-harm in the past year (at the time of sample selection 20/04/05) were invited to participate in this sub-study. This utilised responses from RELACHS 3 questions 36-36.2, addressing having ever self-harmed, and the timing of the most recent episode (see Box 1, section 4.4.2.1.). Ninety seven participants had reported lifetime self-harm, and 56 reported it in the past year. The alphanumeric study codes for the females who had self-harmed in the past year were listed.

6.3.1.2. Young people who had not self-harmed

A comparison sample was selected, matched by gender, and school class. Being in the same academic year was considered sufficient age equivalence. Fifty-six people who had not self-harmed and 56 people who had self-harmed were invited. The non-self-harmer invited was the female who had not self-harmed, with the nearest birthday after each person who had self-harmed.

Once a person who had not self-harmed had been selected, the self-harm data was also removed from the database, leaving a list of codes with school and class name. The names for all selected participants were then located from the class lists, arranged in alphabetical order within each class for the final pilot sample.

The names and codes used for conducting the study had no pattern or ordering to indicate which pupils had or had not self-harmed. Thus the researcher was not aware which pupils had self-harmed when schools were approached to invite the pilot sample to participate.

The process of inviting young people to participate in the pilot study is in the Qualitative study protocol (Appendix 6). As the pilot study informed the main qualitative study reported in Chapter 7, the protocol used for piloting is included within the protocol for the main study.

6.3.2. Assessments

6.3.2.1. Mental health

The Clinical Interview Schedule – Revised (CIS-R) was used to assess common mental disorder (Lewis et al. 1992). The CIS-R was chosen as it was appropriate to be administered by a lay-interviewer, and a single interview with the participant would generate a rating of psychiatric disorder. The self-report CIS-R has been previously used with adolescents (Patton et al. 1997), without the requirement of additional parent or teacher interviews. It has also been used with other ethnically diverse adult samples in the UK, such as the EMPIRIC study (Weich et al. 2004). Direct questions about mental health were considered appropriate for assessment of mental health status of adolescents, as direct questions are not known to increase the risk of psychological morbidity or mortality (Hodges 1993). A total score of 12 or above was considered as a case, indicating minor psychiatric disorder (Lewis et al. 1992).

6.3.2.2. Coping strategies

An adapted version on the A-cope assessing adolescent coping strategies was used (Halvarsson et al. 2001a;Patterson & McCubbin 1987). This scale lists actions a young person might take to cope with feeling stressed or upset. The response options were modified from closed response “yes/no” to the frequency options “Never”, “Hardly Ever”, “Sometimes”, “Often”, “Most of the time”, administered in pen-and-paper format. Notes on the adaptation, are fully outlined in the study protocol, (See Appendices 6 & 7). The changes included making the terminology more appropriate for a multi-ethnic, multi-faith sample, and updating dated phrases and pastimes, such as “playing video games”.

6.3.2.3. Social Support

The assessment of social support was taken from the ‘confidantes’ section of the Self Evaluation of Social Support, referred to as the SESS (Brown et al. 1986;O'Connor & Brown 1984). Each participant was asked to name who they would talk to if they had a problem, and the first two confidantes named were noted. Participants were then asked to name their three ‘closest people’, and answer open questions about confiding in each of those people in turn (see Appendix 8).

These questions aimed to explore the relationship between the participant and their confidantes. Other issues included the nature of support desired and received. These questions also facilitated exploration of participants' views on disclosure of self-harm in comparison with other problems. If a participant had not disclosed self-harm to the researcher, they were asked about "a time that had been difficult for them". Questions applied to the 'current' time period at interview and the past 6 months.

6.3.2.4. Self-harm

The self-harm questions used in RELACHS 3 (see Box 1) were administered in pen-and-paper form for the participant to complete again. The questions enabled the researcher to raise the topic of self-harm with the respondent, and assess whether young people answered these questions differently face-to-face, compared with the classroom-based questionnaire. As the question refers to the most recent episode, it was not intended for test-retest reliability rating, as it may refer to different events should participants have hurt themselves between the two assessments.

If the participant reported any self-harm, the written questions were followed by some brief verbal questions about their experience of self-harm, and the circumstances surrounding their initial harming behaviour. Open-ended questions were asked to explore narratives about self-harm and if there were common elements across personal accounts of self-harm.

The following topics were briefly explored:

- The timing of their first and most recent self-harm
- Their own experience of self-harm
- Initiation of self-harm; precipitating factors, emotional state, expectations, planning
- Events preceding their initial self-harm
- Repetition of self-harm
- Perceived influences on harming behaviour

As this was a time-limited feasibility pilot, the scope for developing the topic guide was limited. Nonetheless, two further topics were included for participants later in the data collection;

- Disclosure of self-harm
- General attitude to and understanding of self-harm by self and others

This qualitative section explored the feasibility of discussing self-harm in an interview with adolescents. The majority of the questions focused on the circumstances surrounding the harming behaviour, and piloting results provided a basis from which to develop a more comprehensive qualitative study.

6.3.3. Procedure

This pilot was given ethical approval by East London and The City Local Research Ethics Committee 2 as a substantial amendment of RELACHS Phase 3. A Protocol for Child Protection and Risk was developed and a consultation panel was established, including senior consultants from the RELACHS study and the Named Doctors of Safeguarding Children in Newham, Tower Hamlets and Hackney. This is included with the study procedures undertaken, shown in Appendix 6.

Sub-study information, participant invitations and parental opt-out forms were either given to participants face-to-face (n=35), left with or posted to each school to send out to pupils (n=77), depending on whether the pupils were in their last week of school or were already on study leave (Appendices 9 & 10). Teachers were also given information about the study (Appendix 11). This ensured that the initial approach to the sample was through their secondary school. The young people were asked to give further contact details if they were interested in participating. Twenty-two participants agreed to be contacted again after this initial invitation.

If participants had not responded to the initial invitation, their codes were used to ascertain whether they had given their consent to be contacted via their postal address in RELACHS Phase 2. Twenty-seven young people who had given consent at that time were then sent a pupil invitation, a parent opt-out form and a freepost return envelope. A further five participants opted in following this mail-out. Figure 5 presents the sampling for the pilot study.

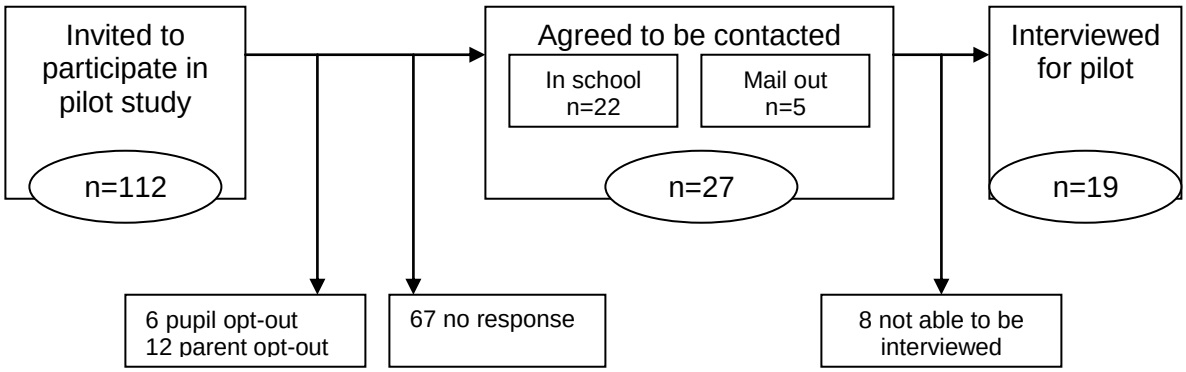

Figure 5: Pilot study sample

Interview sessions were arranged between the researcher and participants over the phone. Each participant was given the option of going to Queen Mary Mile End campus, and at least one other choice of venue such as their secondary school or Connexions, a youth service and information provider with a centre in each borough. A follow-up letter was sent, confirming the time, date and details of the venue and the researcher confirmed the appointment the day before the assessment. Travel costs were reimbursed for all participants.

Participants were given further verbal information about the study on the day of the interview, and signed to give informed consent (Appendix 12), in addition to verbal consent for the session to be recorded. Assessments were administered individually. At the end of the sessions, participants were asked if they had any questions for the researcher. Participants were also given leaflets for local services. All participants were sent a follow-up letter after the session, to thank them for participation.

Liaison teachers were asked informally about their thoughts about this research within schools, and potential considerations when planning future studies, as minimising the burden on schools is a key consideration when designing school-based research.

6.3.4. Analysis

The data from structured assessments was entered by the researcher. Recordings of the open-ended questions from session were transcribed to use in analysis along with notes taken during and after the session. Quantitative analysis was conducted using SPSS

(Version 13). Due to a small sample size, only descriptive statistics will be presented for the structured assessments, where there were sufficient numbers for meaningful analysis.

The qualitative data from further questioning about self-harm was analysed using framework methodology. Matrix-based charting the contents of the interview facilitates thematic analysis between and within participants (Pope et al. 2000;Ritchie et al. 2003b). The thematic coding was an evolving process, with each new code emerging from the data being listed and then returning to the data to assess other aspects of that topic. Framework analysis is described in greater detail in section 7.7. All of the interviews were conducted before the data was thematically analysed, which justified the use of a framework approach to analysis.

6.4. Results

The pilot study informed the methodology and content of the main qualitative study. These issues will be discussed in turn.

6.4.1. Participants

Participation status is shown in Table 56. Nineteen people participated in the pilot study, out of 112 who had been invited. The low response rate implies that research of this nature requires a large number of people to be surveyed in order to recruit an appropriate sample for interview. The participants who had and had not self-harmed were from a variety of ethnic groups, shown in Table 57. The ethnic diversity of the population is reflected in the multi-ethnic sample who reported self-harm. Eighteen participants were 16 years of age, and one participant was within two weeks of turning 16.

Table 56: Number of participants and non-respondents by self-harm status

Response to invitation to participate	**Pupils who had self-harmed in the past year** n	**Pupils who had not self-harmed in the past year** n	**Total** n
Participated	13	6	19
Pupil Opt-out	2	4	6
Parent Opt-out	4	8	12
Consented but unable to attend interview	4	4	8
No response to invitation	33	34	67
Total	56	56	112

Table 57: Pilot study sample characteristics and self-harm status

No.	Age (yrs)	Ethnic Group	Self-harm from questionnaire	Self-harm from interview[α]
1	16	Black Caribbean	In the past year	Had self-harmed
2	16	White other 'European'	In the past year	No self-harm mentioned
3	16	Black British	No self-harm	No self-harm mentioned
4	16	Asian British	In the past year	No self-harm mentioned
5	16	White UK	In the past year	Had self-harmed
6	16	Asian British	In the past year	Had self-harmed
7	16	Black African	No self-harm	No self-harm mentioned
8	16	Black Caribbean	Self-harmed over a year ago	Had self-harmed
9	16	Pakistani	In the past year	Had self-harmed
10	16	Bangladeshi	In the past year	Had self-harmed
11	16	Indian	In the past year	No self-harm mentioned
12	16	Pakistani	In the past year	Had self-harmed
13	16	Indian	No self-harm	No self-harm mentioned
14	15	Black African	Self-harmed over a year ago	No self-harm mentioned
15	16	Indian	In the past year	Had self-harmed
16	16	White & Black Caribbean	In the past year	No self-harm mentioned
17	16	Pakistani	In the past year	Had self-harmed
18	16	White Turkish	Self-harm in the past year	No self-harm mentioned
19	16	Black African	No self-harm	No self-harm mentioned

[α] Participants who talked of their own self-harm in the interview were asked further questions, discussed in section 6.4.3.

Timing of the interviews

The interviews lasted 40-60 minutes. Exploratory open-ended questions about self-harm were asked for 2-10 minutes.

6.4.2. Results from the structured assessments

Results from structured assessments will be discussed briefly where analysis was feasible, with emphasis on the qualitative results from open questions about self-harm.

Mental Health

Eleven of the 15 people who reported lifetime self-harm, and one of the four who reported no self-harm were considered to have common mental disorder (a score of 12 or above). As the CIS-R assessed current mental health, caseness was compared with self-harm in the preceding year. 9/13 of those who had self-harmed in the past year, and 3/6 of those who had not, were CIS-R cases.

Coping strategies

Frequencies were counted for items on the A-Cope; however, these results will not be presented. Having data for 19 participants split into two groups based on self-harm status, there was limited variation across the 57 items included in the pilot. There was insufficient

data to assess whether the factor structure agreed with the original A-Cope (Patterson & McCubbin 1987), or adapted A-Cope-S (Halvarsson et al. 2001a).

Social Support

The responses to open-ended questions have been summarised below. Each participant named two confidantes and their relationship to those people. The confidantes were most frequently a friend (10/38) or a best friend (8/38). Twelve participants named family members as confidantes. Three participants spoke of confiding in a boy or girlfriend and three either refused to name or could not think of another person in whom they would confide. As the numbers were limited, any differences between participants who had and had not hurt themselves were not clear.

Each participant was then asked to name their "three closest people", prior to answering further questions about their relationship with that person and the support they provided. The "close people" showed a similar pattern to the confidantes, with participants most frequently naming friends, mates or best friends. A variety of family members were named, most commonly a sister or step-sister, cousin or mother.

The majority of close people reported were female. Of those who had ever self-harmed, 29/42 close people named were female, as were 7/12 named by those who had never self-harmed. There were three participants, all of whom had self-harmed at some point, who refused to give any information about one of their close people. The majority of close people were around the same age (15-16 years) for the people who had (25/42) and had not self-harmed (5/12). Close people who were older family members such as older siblings, parents or aunts, were mentioned by participants in both groups.

The length of time participants had known their close people varied. Most participants had known their close people either all of their lives or for 2-5 years, which may indicate friends from secondary school. Most of the participants who had self-harmed (24/42) and all of those who had never harmed reported that they would ask their close people for help.

When asked for a recent example of how this close person had helped them, a range of responses were given. Help with money, exams, talking to teachers if they were in trouble, being given advice and help with accommodation, or offering 'a place to go' were mentioned by participants, irrespective of whether they had self-harmed. Being bought possessions was only mentioned as help by people who did not report self-harm. The girls

who reported self-harm also mentioned these close people protecting them, taking charge, sorting things out for them, calming them down or cheering them up. Four participants who had self-harmed did not have an example of how a close person had helped them.

The people who disclosed self-harm in the interview were asked about the response of their close people to their self-harm. A number of participants claimed not to have told anyone, and even if other people had found out, they would not have wanted to tell them. Responses included being lectured and advised about alternatives, asked why they had done that, and told it was not the right thing to do. These participants mentioned knowledge of how the other person felt at the time, expressing emotions such as anger, distress and shock. Some participants referred to more passive responses, where the other person did not know what to say, just listened, or made light of it and tried to cheer them up. A few participants made reference to reciprocation as they also looked after their close person.

Participants who had not disclosed self-harm were probed about the role of close people when they were having a difficult time in their life. Would they be told? How did they respond? What sorts of things were going on at that time? Issues raised by these participants included exams, arguments or trouble with family or friends. A number of participants claimed to have not confided in their close people. Others reported that they were listened to, advised and cheered up by their close people.

The young people talking about issues other than self-harm also mentioned feeling reassured, and understood or that the other person related to their problem, possibly having had similar experiences. There was relatively less focus on the emotional response of the confidantes, and if it was mentioned, it was not distress or shock being expressed, but rather their close people being calm or reassuring. These participants highlighted practical issues of their friendship, such as the proximity in which they lived, or the amount of time they spent together. Reciprocal support, trust and a similar sense of humour were spontaneously mentioned. One participant referred to a cultural bond being important when confiding in others.

Self-harm question from RELACHS

This section will outline responses to the written self-harm questions, and section 6.4.3. will expand upon the qualitative data. Repetition of the self-harm question used in RELACHS 3 facilitated some reliability testing of the measure. However, as there was up

to 6 months difference between the measures, only the lifetime binary (Yes/No) question could be assessed for reliability. Disclosure of self-harm varied between the questionnaire and the interview. Two of the participants selected as non-self-harmers reported having ever self-harmed in the questionnaire, but not within the last year. This had not been factored into the sample selection, based on self-harm in the past year. Of the fifteen participants in the pilot who had reported self-harm in the questionnaire, nine reported ever having harmed themselves in their interview. All four participants who reported never self-harming in the questionnaire also reported no self-harm at interview.

There was variation in the way that young people had hurt themselves. Although they may have been describing different episodes, reporting different behaviours highlights the potential variation of self-harm.

Participant No.9 claimed in the interview that she had hurt herself on only once as she did not get anything out of it. However, the response form her questionnaire implied more than one episode and method of self-harm; “I would burn my thighs” along with “I scratched the skin off my thigh (one day) and on the next day I put out my cigarette on my arm so I left a burn mark”. There are similarities in the reported behaviours, however, the differences raise issues about the reliability of asking the young people to “give as much detail as you can” about their last harming episode in a questionnaire with limited space. Alternatively, the issue with reliability may stem from asking about self-harm in face-to-face interviews.

Differences in accounts could also indicate that the young person may have varying thoughts about her harming behaviour with a greater gap between the incident and the description. This could illustrate the way in which the behaviour may be ‘played down’ when it is discussed with someone else, as opposed to writing it down in a coded questionnaire. It is possible that these young people may use different methods, depending on their intentions at the time.

6.4.3. Results from open-ended questions about self-harm

There were nine participants who answered further questions about their self-harm, noted in Table 57. Participants will be referred to by their participant number, shown in the table, with age and ethnicity if quoted directly.

Accounts depicted each individual, within a **social context**, at the end of secondary school (15-16 years). For many young people, key issues at this time of life centre on family, peers, relationships, school and schoolwork. All of these could function as stressors, especially if the young people perceived a lack of support. Three participants made direct reference to feeling pressure from those around them when explaining factors which preceded their self-harm.

> *"And, at, at that time I was really, like communicating with no one, like my family, and friends and all…*" (No.12, female, 16, Asian Pakistani)

The sense of **identity** expressed by participants was more implicit than explicit, and no participant clearly explained how they saw themselves relative to their self injurious behaviour. Issues related to their identity as they discussed their experience of self-harm included being at school, having a sense of control over their lives, relating to their family, religious beliefs, having friends, or feeling isolated from those around them.

> *"I felt there so much pressure on me, and, um everything happened at once and I felt I couldn't handle it."* (No.10, female, 16, Asian Bangladeshi)

Reference to their **psychological state** was colloquial or offhand. Although some participants discussed feeling "bad" (No.15), or "depressed" (No.10), none of them acknowledged such feelings within the context of mental health problems.

> *"I know it sounds crazy, I'm not crazy or anything."*
> (No.8, female, 16, Black Caribbean)

In most cases, the descriptions of precipitating factors included reference to the participant's **affective state**. Emotions described before self-harm fell into three main groups; feeling upset (No.5, No.6, No.15, No.17), feeling angry (No.15, No.8, No.10, No.1) or feeling stressed (No.9, No.12). Seeking relief was a common motivation for the act. A feeling of confusion, relating to day-to-day experience was also expressed by three participants, normalising the behaviour.

> *"Um, I just remember I was really upset and…it just sort of happened and I found it… like helped me relieve, what I was feelin' sort of thing. So I just continued to do it whenever I was upset…"* (No.5, female, 16, White-UK)

> *"I before I done it I felt a bit, um confused, and maybe a bit … I felt normal, but just, maybe a bit more confused than normal…"* (No.9, female, 16, Asian Pakistani)

Young people reported a specific incident or combination of **precipitating factors**. Participants had a number of short and long-term stressors building concurrently, and the cumulative effects of these pressures led to their self-harm. There was reference to SATs (No.8), GCSEs (No.10, No.12) and coursework.

> *"It was, um, to do with schoolwork… like coursework and stuff, sort of like had to be handed in on this date or that date, like, work and being pushed by teachers and, parents and… it was a bit too much."* (No.1, female, 16, Black Caribbean)

Common issues leading to the first episode of self-harm included the loss of a close person, conflict with friends, family or within a relationship. Two participants referred to friends dying (No.5, No.6), and a third referred to the death of a role model (No.8) as stressful events, heightening the impact of other daily stressors. Other participants discussed self-harm as something they had seen evidence of at school, or in the media.

> *"I think I find that some people, like, do it for show. So I came to school, basically, over the past year I found out that, quite a lot of people are rolling up their sleeves. And you'd see that they'd like hurt themselves, but you thinking, you just wonder to yourself 'how stupid are you?' Because they'd roll their sleeves up for you to see. And I, and I just thought, just pointless, 'coz I didn't get nothing out of it."* (No.9, female, 16, Asian Pakistani)

Four participants described a need for **control** over themselves or the pain they felt. The harming functioned as something which made difficult emotions more concrete, and thus manageable. This was expressed in a variety of ways, with some participants being eloquent and others providing a simplistic, raw explanation.

> *"Before I feel like I just need to do somethinnggg… "*
> (No.17, female, 16, Asian Pakistani)

> *"'Cause if you're hurting inside, there's nothing you can do… really, at that point to stop it. But if like, you cut yourself, you can … sort of, your concentration's on that. But kind of, moves the pain to the outside, which you can... deal with, like, heal it, stuff like that."*
> (No.5, female, 16, White-UK)

Some of the participants acknowledged self-harm as a method of **coping**. Alternative coping strategies, such as talking to friends or family, or expressing their feelings in other ways may not have provided the required relief.

> *"I, like didn't have any actual way to give out my anger. I'd had temper tantrums before, but sort of grown out of that, where I broke stuff, mirrors and stuff, or … cups, stuff… I tried so many methods, 'cause I, when I, like, get angry I like, can't control myself… I tried writing… poetry or something, or writing songs… or listening to music, but none of that seemed to work."* (No.1, female, 16, Black Caribbean)

Five participants described a lack of awareness of their **initial harm**, reporting that it 'just happened'. Their accounts implied that they were not aware of it being a coping strategy, only that they had done it and felt better (No.5, No.6, No.1, No.12, No.17). They may not have an explicit understanding of their behaviour, may not have consciously decided to self-harm or they did not wish to talk about it.

> *"Um, well, at that moment, um, I didn't, I wasn't planning to do it. I just thought right at that moment 'OK, I'm gonna do it'."* (No.12, female, 16, Asian Pakistani)

> *"I can't really remember doing it. I don't know why I did it."*
> (No.6, female, 16, Asian British)

Previous experience of self-harm influenced understanding of harming behaviour. When discussing recent episodes, participants who repeatedly self-harmed described the purpose it served for them. Most reported making a conscious decision to harm, knowing that they were doing it, and what they were intending to feel after harming.

> *"I don't know, it just feels good for that moment while there's blood coming out of your skin or whatever, yeah. It just feels so good. But then afterwards you feel the pain, that's when you think about it, you think to yourself, why am I so stupid for, why did I do it for? … but, um, like I don't think it's stupid. But while you actually cut yourself, while you feel the blood come out it feels so good. You feel as though your… the problems coming out, the problems feel so relieved, yeah"* (No.10, female, 16, Asian Bangladeshi)

There was a variety in the **awareness of intentions** when self-harming. Three participants talked of 'running away' or 'escaping' their problems. These participants had higher suicidal intent associated with their actions.

Three participants mentioned wanting to harm someone else, but harming themselves instead (No.8, No.1, No.10). These accounts differed, one relating to uncontrollable anger which might lead to "something or someone" being harmed (No.1). The second self-harmed to make a statement, wanting to "hurt somebody else by doing it" (No.8). The third account described hurting herself as an alternative when unable to "hurt that person, or whatever the problem is" (No.10).

Five participants (No.8, No. 9, No.1, No.12, No.17) described **repeated impulsive** self-harming. They expressed awareness of when they did it and precipitating factors, but with limited discussion of any meditative reasoning behind their harming.

"Spur of the moment. Go into my room. Angry. Hit the wall…. but I can't feel the pain. I'm angry." (No.1, female, 16, Black Caribbean)

The **methods** chosen by the young people were explored tentatively, as most participants were reluctant to discuss the issue. Some participants preferred to give a simple explanation or not talk about what they had actually done, despite being comfortable explaining the reasons why they had done it. Other participants described their actions more openly, giving more detail about the situation and their preparation.

"Um, I kind of cut my arm a bit." (No.17, female, 16, Asian Pakistani)

"I went to shopping, I bought some packs, and went home. But not all in one go… just like within an hour, just taking like, like ten – like a box every like, ten minutes." (No.8, female, 16 years, Black Caribbean)

Participants downplayed the **physical aftermath** of self-harm during these interviews. One participant reported that she did not tell anyone about her first overdose at the time, but later mentioned that she had stayed in hospital for a couple of nights (No.10). Other responses included sleeping after an attempted overdose (No.8), hiding it from others (No.9), and not intending for their scars to be seen afterwards.

Responses to the physical injuries related closely to the **affective state** participants were in following self-harm. A feeling of relief was described by four participants. Some felt quite mixed about their harm, reporting a variety of feelings. For example, the first time No.15 self-harmed, she "felt bad doing it" and she then described repeatedly doing it when she was angry to feel better.

The **outcome of the self-harm** influenced the discussion of suicidal ideation. For example, having made a failed suicide attempt, the young person may wish to represent her intentions in a different light afterwards. Three participants clearly expressed suicidal thoughts when recounting their self-harm (No.8, No.10, No. 12), including one-off attempts at taking their own life which they did not wish to repeat.

Two participants highlighted that self-harm did **bring relief, but did not change the situation** which had caused the distress. Their harming was viewed as an expression of their emotions, functioning as a short-term strategy, without providing a solution to the situation. No.10 and No.1 reported that they would think it was stupid afterwards, but then would harm themselves again when they were distressed. Others who did not experience

any benefit at the time expressed more disparaging views of their experience, claiming they would not be likely to harm themselves again.

> *" I just thought it was kind of stupid." (No.6, female, 16, Asian British)*

> *"Frustrated 'cause of, 'cause of the… problem which had occurred, but relief because- I don't even know why… I don't know why I was relieved, like it felt… like some of the weight lifted off my shoulders." (No.1, female, 16, Black Caribbean)*

Accounts of self-harm were coloured by experiences after the act itself. Some participants sounded certain to repeat the behaviour if in similar circumstances again. Their response to self-harm related to the function it served for them; whether it provided the outcome they were looking for, expressed how they felt, or prompted a response from other people.

> *"Before, I felt like I wanted to die, and after I … I regretted it because obviously I hurt everyone around me, my family my friends, like, everyone. I hurt everyone around me, so I regretted it*." (No.12, female, 16, Asian Pakistani)

As cutting or burning may leave physical evidence on the body, scars may change self-harm from a private behaviour to a public display of previous actions. Three participants reported that self-injury had subsequently brought about changes in their life or support network to reduce the pressure and isolation they had previously been experiencing (No.5, No.10 and No.12).

The **role of other people** in relation to self-harm was intertwined with the **disclosure** of harming behaviour. Some participants were certain that nobody else was aware of their self-harm. Others claimed to have been **'found out'**, rather than having intentionally disclosed their self-harm. No participants openly stated that they had told anyone about hurting themselves before. Of those who believed their behaviour was secret, there was a determination to keep it secret.

> *"It might have been a little stupid but I, I wasn't, the intention wasn't to tell anybody anything... and it wasn't to hurt myself either, it was just… dunno… it seemed fine… but I just thought 'whatever'. And I wasn't going to tell nobody. It didn't hurt or nothing, just… It was w… it's not so much self-harm, it's just a bit of, you know. It wasn't nothing much…"*
> *(No.9, female, 16, Asian Pakistani)*

Four participants reported being "found out". They were guarded in discussing the circumstances under which their behaviour was discovered. None reported disclosure of their harm as having been a positive experience. Some participants discussed the response of the other person, whereas others focused on how they had felt about being

discovered and how the public nature of their self-harm influenced later actions. Self-harm becoming public amongst family and friends was reported with hesitation as it seemed to be a negative experience, causing further distress for the young person, or feelings of anger or regret.

> *"Oh my god. I feel like beating that teacher up. No, um, because they told me it was going to be confidential and stuff like that and, yeah, my parents won't find out and no one's going to find out. But then the police is involved and some stupid social worker and different counsellors, and everyone else is involved. And then half the school finds out as well, so it just really pissed me off." (No. 10, female, 16, Asian Bangladeshi)*

> *"Oh my mum saw it the other day, and um, she um, she started crying…*
> *I was upset, so I cried with her." (No.15, female, 16, Asian Indian)*

Three participants made reference to further **professional help** relating to their self-harm. Two participants made passing references to having been to hospital, but did not discuss that experience further. One participant who had been discussing her self-harm with a social worker reported feeling more positive, and that things were easier with someone to talk to (No.5).

> *"Oh I, I went to hospital, yeah. Overnight, I went to hospital. Oh, and a psychiatrist did come, did come and ask me a few questions… but that was it really…and if I wanted to I could see a psychiatrist, but I chose not to. I mean, they gave me all the information, but I didn't..." (No.12, female, 16, Asian Pakistani)*

The two participants who had ongoing input from services discussed emotional pain in relation to physical pain, or the physical release of emotional distress. Other participants mentioned pain and relief, but in a less **scripted** manner. It could be that these two participants had experience verbalising their thoughts and feelings about self-harm, whereas the others did not.

> *"It sort of, like, took the pain from inside and brought it out. 'Cause it's sort of like pain you can deal with, rather than, not being able to deal with it. That's what I found."*
> *(No.5, female, 16, White-UK)*

Participant No.10 described a variety of self-harming experiences. Her account included repeated non-suicidal self-harm as an expression of anger and seeking relief, this being openly checked by a teacher at school, which inspired her to reduce her harming behaviour. Two suicide attempts were also reported, followed by claims of increased social support from friends and family, reduced access to means and religious belief which would prevent her from harming again. This example highlights the complexity of self-harm and

how it could be a changeable behaviour. Different aspects of self-harm may be influenced by input from different people within a young person's life, including family, friends, school, their religion and culture. The response to or understanding of self-harm could change within a seemingly cyclical behaviour of harming a number of times. The accounts given of self-harm may also incorporate the young person's perceptions about what their audience may wish to hear.

> *No.10: Um well, the pressure – there was more pressure coming along the way that made me want to do it again, but then I got support from a lot of people, like my friends and a few family members, and they prevented me from doing it again.*
>
> EK: How did they help prevent you from doing it?
>
> *No.10: Um, well, they, they hid the tablets, for one. And, but, um, they just talked to me about how, basically they put the religious side to it as well, because in our religion you're not allowed to take your own life away. It's a sin. And things like that they actually made me think there's no point and, at the end of the day we're gonna have to live with, difficulties and face situations like that. So, they talked me through it, and I… just don't feel like doing it again.*
>
> *(female, 16, Asian Bangladeshi)*

The different elements within these narratives could all feasibly interact. For example, the outcome of self-harming may influence the young person's social context, identity and attitudes to self-harm, along with their inclination to harm again, and whether it should be disclosed to others. Their feelings may influence their intentions, actual harming behaviour and desire to disclose their self-harm. Self-harm is a complex, variable act with both public and private outcomes.

6.4.3.1. Dealing with follow-up and child protection issues

All participants were given information about local services at the time of the interview and told about ways through which they could contact appropriate agencies, should they need to seek help. All participants were also sent a thank you letter with further contact details should they be required. If participants disclosed ongoing distress, they were encouraged to seek help through the appropriate agencies.

Sensitivity was required in interviewing young people about this emotive topic. Most participants claimed to have never spoken about their self-harming behaviour, or having only spoken about it in a limited way. Some participants responded to questions, seemingly looking for the "right" answer. Some seemed to need permission to stop talking in the interview, having become uncomfortable disclosing their distress and self-harm, or if

becoming affected emotionally by the content of what they were saying. This issue was pertinent when considering how to address a potential power imbalance between the interview and participant in a more in-depth study.

6.5. Findings to be applied in the main qualitative study

6.5.1. Methodology

The pilot showed that it was feasible to interview adolescents on issues including self-harm. The personal nature of each experience indicated that individual interviews would be more appropriate than any group-based data collection. The interviewing style should aim to strike a balance between sensitivity without being tentative when exploring self-harm. Due to the scope for conducting more in-depth interviews with a small sample, further use of structured assessments was deemed less important than using time to develop rapport with the participant. Thus structured assessments would be appropriate for sample selection, and not within individual interviews.

As this pilot was conducted in the summer holidays, following the end of Year 11, there may have been some bias in the sample, considering which participants were able to meet with the researcher in their own time. Ideally, future research would be conducted within the school term. This would enable arrangements to be made with assistance of teachers known to participants. Basing research within schools would ensure familiarity for participants at both a social and environmental level. Research within schools would allow the researcher to open communications between participants and school-based support networks, also reducing potential bias in the sampling if participants were required to be available outside of school hours.

Consultation with teachers about the design of the study re-affirmed that schools were willing to assist with the research if possible, as long as confidentiality was assured. Teachers indicated that it would be preferable for pupils to miss a single lesson for the study if they were required to miss lessons at all, and that it would be preferable for the interviews to be conducted over a limited period of time, scheduled around school exams and inspections. This implied that it would be more feasible to conduct a greater number of shorter interviews, rather than longer or repeated interviews. Such limitations on data

collection have implications for the interview depth and thus the type of analysis to use for subsequent qualitative research.

Conducting a pilot study involves some flexibility as it is exploratory, aiming to inform further research. Nonetheless, rigorous methodology was employed to ensure that gatekeepers and participants were informed, consenting and not at risk in this study. Consideration of ethical issues is paramount in research such as this, and piloting has illustrated that development of a more in-depth study would also require further consideration of ethics. Study timetabling would also need to incorporate sufficient time for separate ethical approval from a number of panels to research such a sensitive topic with potentially vulnerable young people in secondary schools.

As relatively few participants responded to the invitation to interview in the pilot study, a conservative sampling strategy would be required in the main study and facilitate selection of a sample using the desired criteria. The diversity of the population from which the sample was drawn illustrated that young people from many different ethnic groups had self-harmed. Selecting participants on the basis of self-harming experience was sufficient to yield an ethnically diverse sample within East London secondary schools.

Disclosure of self-harm differed between the questionnaire and the interview for six pilot study participants. For further work, it would be preferable to clarify that the researcher was aware of responses given in the screening questionnaire. This would enable purposive selection of the sample, minimising the number of participants who may report self-harm in a questionnaire and not face-to-face.

The issue of confidentiality about disclosure of self-harm was raised repeatedly, and the exact nature of the confidentiality must be emphasised to the participants at both the screening questionnaire and interview. In order to maintain the confidentiality of the interview, it must also be made completely clear when confidentiality would be broken. Although most participants in the pilot study seemed reluctant to take pamphlets about local services, one participant commented that the information would be useful, particularly knowing a number of ways in which they could be contacted.

6.5.2. Thematic content

Key issues from the pilot study to be explored further centre around the participants' difficulty with talking about their self-harm; why they had done it, and the experience itself. The main study may try to expand upon reports of having "just done it" and having difficulty discussing the link between feeling distressed and then self-harming. This may relate to a dissociative aspect of self-harm, the time elapsed since the harm, or a reluctance to discuss or recall the details of the episode. Similarly, further qualitative research could explore if young people's own identities relate to their self-harming, or even if they relate their actions to the term "self-harm".

Different definitions and attitudes to types of self-harm became apparent, which would benefit from further more structured exploration. There was some implication that people who had self-harmed once or more than once described their experiences and attitudes in different ways. Repetition and cessation of self-harm warrant further exploration. The small pilot sample included a range of precipitants, methods and awareness about self-harm. A larger study may be able to identify patterns across participants not evident in this pilot.

There was strong emotional content in descriptions of self-harm, with anger as a common trigger. This merits further exploration as previous research emphasises depression as an emotional precipitant. There was limited discussion of ethnicity or culture in the pilot study however there is scope for that to be developed in further qualitative research.

The brief questioning about disclosure of self-harm provided some commentary about the perception of control. A qualitative difference was reported by participants who talked of choosing to tell another person, as opposed to their self-harm being "found out". This reflects findings from the SESS, where some participants refused to discuss confidantes and others emphasised the importance of how others reacted to their self-harm. There was some evidence from the SESS and open questions on self-harm that the emotional response from others distinguished disclosure of self-harm from talking about other problems. Similarly, there was more discussion of affective help being received by young people who had self-harmed, and more practical help recounted by those who had not. These issues are worth exploring to potentially inform schools and service providers of young people's views on responses to their self-harm.

The narratives about self-harm have been described with a cognitive approach, using concepts of stress, coping strategies, learned responses to ease distress, affective and psychological states. This psychological approach will be maintained for the main qualitative study. Alongside the awareness of the researcher's theoretical approach to this research is the consideration of how that may influence the content of the interviews. As study information and consent forms use terminology such as "coping" and "self-harm", that may prime responses and language used in the participants' accounts. It is difficult to gauge the bias stemming from social desirability, and how accounts may be presented in accordance with what participants think the researcher may wish to hear (Esterberg 2002). These issues will be discussed further with respect to the main qualitative study.

6.5.3. Concluding comments

The exploratory nature of this pilot has provided insight about self-harm in a community sample of young people and also information for the development of methodology for attempting to examine the topic further. The pilot included elements of both quantitative and qualitative methodology. To conduct a higher quality study, these two approaches would need to be distinguished more markedly. The benefits of more in-depth interviews outweigh the use of structured assessments as they were used in this pilot. Structured assessments would only be used in further research within this thesis to select a sample for qualitative interviews.

Piloting illustrated the feasibility of conducting qualitative research on adolescent self-harm, and the careful consideration required when exploring a very sensitive topic with a young, potentially vulnerable sample.

7: Qualitative study exploring self-harm in East London adolescents: Methods

7.1. Introduction

This chapter presents the research methods for the qualitative study, exploring how young people experience and talk about self-harm. This study addresses the fourth aim of the thesis stated in Chapter 1. It is the second part of the sequential mixed methods design for this research (Creswell 2003), conducted after the quantitative study.

The study will be introduced; outlining aims, discussion of ethical issues and justification of the methodology chosen for this work. The procedure of the study, including sampling, data collection and analysis are then described. The results of this study are presented in Chapter 8.

Why conduct a qualitative study on adolescent self-harm?

Quantitative surveys have the scope to identify relationships between factors at a group level, however, they may not have scope to provide insight into underlying mechanisms. Subtle variations and the way in which factors relate may be difficult to measure or capture at a group level. Qualitative methods facilitate exploration with more depth, shedding light on how and why factors may relate (Pope & Mays 1995). Meanings attributed to actions by each individual may mediate the relationship between what he or she does, and the ramifications of such actions (Pope & Mays 1995), and thus qualitative research is appropriate for the exploration of self-harm. Qualitative methods have scope to explore what young people mean when reporting “self-harm”, triggers and their interpretations of such actions within the context of being an adolescent in East London.

The rationale for this study was to explore how a sample of adolescents within the East London community talked about experiences relating to self-harm. This was done to develop and deepen the understanding about adolescent self-harm, adding to the findings of previous quantitative and qualitative research (Bhugra et al. 1999c;Bhugra et al. 2004;Coggan et al. 1997;Evans et al. 2005;Hawton et al. 2002;Mental Health Foundation 2006;Redley 2003;Sinclair & Green 2005).

Support from family has associations with mental health, yet previous research indicates that if young people discuss their self-harm, it is likely to be with a friend (Coggan et al. 1997;DeLeo & Heller 2004;Evans et al. 2004;Fortune & Hawton 2005b). This implies that support from friends is important, perhaps even more so if the young person has poor relations with their family. For this reason, the role of social networks will be explored with individual interviews. People who had not self-harmed will also be included to explore peer views on self-harm.

A recent study noted that further research was required into differences between those with single and multiple episodes of self-harm, particularly exploring why people who have repeatedly self-harmed feel less able to communicate with friends and family (Evans et al. 2005). Discussion of relationships with others will include attitudes towards disclosure of self-harm and the perception of cultural influences on interpersonal relationships, from the perspective of East London adolescents. As this is a community level study, the topic of service provision will be included as an aspect of the young people's help-seeking behaviours, and the reasons they may or not seek help.

Contribution from piloting and quantitative research in this thesis

In addition to previous research on self-harm, the content of this study has been informed by both the pilot study (Chapter 6) and findings from the quantitative study (Chapter 5). The brief questions from the pilot highlighted the difficulty young people had in trying to describe triggers, actually hurting themselves, repetition, cessation and disclosing self-harm to others. These issues were suitable to explore further within the more in-depth study. An example from the quantitative study warranting further exploration relates to cultural identity. The closed response questions did not illustrate definitive associations between self-harm and cultural identity, which may have related to the crude assessment of cultural identity. There is scope to explore this issue further in the qualitative study. This would not be done with the intention of comparing ethnic groups, but rather to see whether culture was spontaneously raised by participants. If it was not mentioned throughout discussion of self-harm in the context of life in East London, it could be explored through prompted discussion.

7.2. Aims and Objectives

7.2.1. Aim

This study aims to investigate understanding of self-harm in a multi-ethnic sample of adolescents. It aims to describe and explore how young people talk about self-harm, disclosure of self-harm, and cultural issues around self-harm in an ethnically diverse community.

This will be an exploratory study addressing the following objectives:

A. *To explore attitudes to self-harm by people who have and have not self-harmed.*
B. *To examine young people's personal experiences of self-harm, including background psychosocial factors, triggers and immediate precipitants of self-harming behaviour.*
C. *To investigate disclosure of self-harm and informal help-seeking in the context of social interactions.*
D. *To investigate attitudes to formal help-seeking and service provision.*
E. *To note whether culture and cultural identity are inherent within accounts of self-harm in East London adolescents.*

This research was designed to allow respondents' views to unfold in response to questions around their identity, social network, experiences of stress and coping, shedding light on the contexts and influences on their behaviour, rather than pointedly focusing on self-harm. These aims also facilitated exploration of the process of self-harm as explained by these young people, including triggers, recollection of events and experience of recounting self-harm to others.

7.3. Study design and choosing a methodology

Qualitative methods encompass a wide range of approaches. The collection, analysis and use of the data varies according to the epistemological stance of the researcher, and the aims of the study (Spencer et al. 2003). Although there are many possible approaches to qualitative study of this nature, such as grounded theory (Glaser & Strauss 1967), narrative analysis (Riessman 1993) or Interpretative Phenomenological Analysis (IPA)

(Smith & Eatough 2006;Smith & Osborn 2003), a general thematic approach has been adopted, using framework analysis (Snape & Spencer 2003;Spencer et al. 2003). The framework approach facilitates analysis within and between accounts, yielding a descriptive account of self-harm as related by young people, and will be described in further detail in section 7.7.

The ontological perspective assumed in using framework analysis is closest to *subtle realism*, an approach which acknowledges as independent external reality that can only be known through socially constructed meanings (Hammersley 1992). This approach has been likened to *hermeneutic realism*, achieved through rigorous empirical research (Liamputtong & Ezzy 2005). The epistemological stance adopted relates to this theoretical approach, primarily based on interpretivism. However, pragmatic issues need consideration when conducting mixed methods research, emphasising methodological rigour as well as couching the research within a theoretical stance (Snape & Spencer 2003).

The methodology to be used for this research stems from practices developed for policy-based research (Lewis 2003), however, in order to extend the application of this research beyond a "problem-orientated" approach (Harding & Gantley 1998), the interpretation of the data acknowledges social and psychological influences on young people's lives. Self-harm was couched within a model of "coping" with stress (Folkman & Lazarus 1988), in a community which includes many different and potentially conflicting cultural influences. The study was designed to explore young people's views on self-harm within their social and cultural context of life as an East London adolescent.

7.3.1. Approach to sampling

It was a challenge to identify a sample that had self-harmed, and had not necessarily sought help. A "screening questionnaire" was developed by the doctoral student to facilitate sample selection in this study (See Appendix 13: Stress, Mind & Body). A detailed explanation of the sampling strategy is in section 7.5. This was adopted as a sensitive means of selecting a stratified purposive sample including young people who had and had not self-harmed (Liamputtong & Ezzy 2005). This method has been used to purposively sample young people who have attempted suicide or self-harmed in previous studies (O'Sullivan & Fitzgerald 1998;Ross & Heath 2002). This design would offer the young

people an opportunity to participate in the study without it leading to their self-harm being identified to others around them. It was assumed that young people would not be forthcoming about their experiences of self-harm if approached in a more public way, or through a strategy such as snowballing (Liamputtong & Ezzy 2005). As Year 11 is the last year of compulsory education, this enabled the study to reach a large range of young people attending their final year of schooling, as was done in the CASE study (Hawton et al. 2006).

7.3.2. Approach to data collection: individual interviews

This study adopted an interactionist approach using the accounts verbalised by participants in response to questions from the interviewer as data (Silverman 1985). Interviews were chosen as the source of the "generated data", as they would enable insights into the participants' interpretations of their personal experiences (Ritchie 2003). It was decided that the presence of other people in focus groups or paired interviews might function to expose a young person's self-harm to others. Thus, in order to maintain participant privacy and to probe how young people explained their own self-harm in their own terms, individual interviews were used.

A semi-structured approach was adopted for the interview process (Britten 1995) to enable the interviewer to cover the topic guide (Arthur & Nazroo 2003).There are varied definitions of "semi-structured" interviews (Arthur & Nazroo 2003;Britten 1995). For this research, the term refers to interviews conducted with a standardised topic guide, discussed further in section 7.6. (See Table 61), with potential variation in the wording of each question, probes and question order, depending on the responses given by the participant. This approach was chosen as the topic of self-harm was viewed as potentially difficult to talk about, particularly in interviews with adolescents. If a topic was too sensitive, questioning was curbed and moved to another topic.

During the interviews, the topic of self-harm was tabled using the screening questionnaire. Other possible approaches to discussing self-harm were considered, such as discussion of a hypothetical vignette or using a representation of self-harm in the media as a prompt (Arthur & Nazroo 2003). However, given that the aims of the research focus on the individuals' experiences, the personal nature of the topic and limited time for conducting interviews, it was decided to refer to the experiences of each participant. Interviews were

conducted over a limited time frame, as participants were nearing their final exams and departure from secondary school. This was an additional reason to use a consistent topic guide in all interviews, rather than a more open-ended approach. There was ongoing reflection on the content of the interviews, which influenced probing questions within the topic guide, as the data collection progressed.

7.3.3. Approach to data analysis

It was decided at the outset of this study that the design would be developed in accordance with the principles of a framework approach (Ritchie et al. 2003b), viewing the semi-structured interview data from a thematic perspective, to gain insight into self-harm as presented by these adolescents. This included within and between case analyses, exploring self-harm as a social phenomenon, alongside personal experience of harming.

Thematic analysis involves coding sections of data in individual interviews, and comparing it with data relating to similar themes in other interviews (Spencer et al. 2003). Thematic analyses facilitate exploration of social phenomena described by different individuals, with less emphasis on the experiences of each individual, compared with, for example, narrative approaches (Liamputtong & Ezzy 2005). Narrative analysis is concerned with the individual's story, their understanding of it, and how it is told (Liamputtong & Ezzy 2005;Riessman 1993;Spencer et al. 2003). The themes within the analysis reflected the structure of the topic guide, yet the variation in response provided insights into each issue explored within the interviews. The process of analysis will be described in more detail in section 7.7.

This methodology was chosen with consideration of other approaches to qualitative research such as grounded theory (Glaser & Strauss 1967). As the research questions had specific issues to explore, a more grounded approach was not viewed as appropriate, and this research was aiming to describe this phenomenon in this population, rather than generate theory. Additionally, the use of semi-structured interviews would not have suited a more grounded approach. Although there was some reflection on the contents of the interviews during the data collection, there was not scope within this design for the more iterative approach of constant comparison and the ongoing nature of theoretical sampling, where new participants would be selected on the basis of characteristics relevant for further exploration of the theory being constructed (Glaser & Strauss 1967).

Some of the aims of this study would be philosophically suited to a psychologically orientated phenomenological approach such as Interpretative Phenomenological Analysis (Adams et al. 2005;Smith et al. 1999;Smith & Eatough 2006;Smith & Osborn 2003). IPA is a methodology which aims to research how individuals interpret and make sense of their own experiences (Smith & Eatough 2006;Smith & Osborn 2003). That again has more of an emphasis on organising and explaining the individual experience, rather than contextualising experiences, as is appropriate for this piece of research. The interview length and depth, combined with the desire to include a contextual element; looking at between participant comparisons and social influences relating to self-harm, justified the decision to use framework methodology. However, some consideration was given to elements of phenomenology while conducting this study, as it was assumed that in the interview process, participants were interpreting and explaining their own experiences (Smith & Eatough 2006). Additionally, the brief window for data collection in schools led to interviews being conducted in close proximity, and requiring the majority of the interviews to be completed prior to analysis.

7.4. Ethical considerations

Conducting qualitative research with young people on sensitive issues including self-harm, mental health and culture requires careful ethical consideration. The safety of the young people participating in the research is of utmost importance and overshadows any research agenda.

In order to obtain informed consent it is important to include the breadth of topics to be explored in written and verbal information for all parties required to give consent for a school-based study; teachers, parents and the young participants themselves. Assessments and methodology used need to be age-appropriate and also conducted in a respectful manner that is not disempowering for the participant. Assurance of responsible confidentiality is vital. That is, ensuring that participation would not have any negative ramifications for the participating schools or young people. However, research confidentiality also overlaps with concerns about child protection (London Safeguarding Children Board 2007). Qualitative research about mental health and self-harm may incorporate disclosure of risk by the young person, which may lead to the “the researcher versus therapist dilemma” (Alty & Rodham 1998) in which there may be conflicting

motivations for the interviewer to respond as a researcher or as some form of therapist. Protocols were developed in collaboration with psychiatrists and child and adolescent specialists to minimise the risk to participants. These provided clear guidelines and strategies for the interviewer if a participant appeared to be at risk (see Appendix 6).

Researchers have a responsibility to couch their work within the current provision of support and health-services. When conducting school-based research, ethical responsibilities can be addressed through debriefing participants, informing school support services about the study and also clarifying the role of support within the school to participants (Alty & Rodham 1998).

7.4.1. Ethical and Research Governance approval for qualitative study

This sub-study of RELACHS was approved by COREC (Central Office for Research Ethics Committees) East London & The City Health Authority Local Research Ethics Committee 2, following approval and agreement of sponsorship from the Barts and The London NHS Trust Joint Research and Development Office. The study was granted approval by COREC as an independent study, unlike the pilot which was approved as a substantial amendment of the main RELACHS study. Following this approval, the study was tabled for review by the Research and Development leads for the Local Education Authorities in the London Boroughs of Newham, Tower Hamlets and Hackney where RELACHS had been conducted. The Newham Research and Information Manager for Children and Young People's Services, and Head of Research at the Hackney Learning Trust approved the study as presented. The Tower Hamlets Performance, Research and Statistics Team referred the study for review by the Research Governance Panel. This panel approved the study; however, they requested substantial changes to methodology concerning confidentiality and the child protection procedures. As this was not possible given the time constraints, no qualitative data was collected within Tower Hamlets.

7.5. Sampling and recruitment

The sampling strategy for the qualitative study was developed after the RELACHS study, the pilot study, and with the influence of previous research (Evans et al. 2005). This led to the decision to select a community-based sample of East London adolescents who had

never self-harmed, had self-harmed once or more than once. These groups were chosen with the aim of addressing the research questions and to provide rich data about different exposure and experiences of self-harm, focusing on the phenomena being explored (Curtis et al. 2000).

Selection criteria were kept at a minimum to avoid screening based on issues the study was aiming to explore. Ethnicity was considered as criteria for selection; however it was assumed that the sample would be ethnically diverse, given the population from which it was being drawn. Rather than selecting on the basis of ethnicity, it was decided to see whether ethnic differences became apparent through the content of the interviews. It was noted that a larger number of interviews may be required to include the ethnic and cultural heterogeneity of the population (Ritchie et al. 2003a).

This study aimed to interview 30 young people, ideally comprising three groups of ten pupils according to their experience of self-harm. As self-harm was reported by approximately 10% of the participants in RELACHS Phase 3 and previous research (Hawton et al. 2002;Hawton et al. 2006), an estimated 300 people would be required to complete the screening questionnaire to achieve the target sample. However, as piloting indicated that a low response rate was likely, due to pupil and parent opt-out, school timetabling and availability of partcipants, a sample well in excess of the desired number of interviews were invited. Following piloting, the doctoral student was also aware that reports of self-harm may vary between questionnaire responses and face-to-face interviews.

7.5.1. Screening questionnaire used to identify sample for interviews

The sample was selected with the use of a screening questionnaire given to year 11 pupils, to identify potential interviewees on the basis of their self-harm status. Consideration was given to the approach to sampling, as it was a purposive sample, aiming for analytic generalisability, not attempting to provide any statistically generalisable results (Curtis et al. 2000). Questions on self-harm were couched within questions on stress, coping and social support, and thus other questions in the survey provided a context for the enquiry. The screening questionnaire was also used within the interviews to stimulate discussion about the issues it addressed, complementing the topic guide (See Table 61).

To select a sample for interview, all secondary schools in Newham and Hackney which participated in RELACHS were invited to participate in the study (Stansfeld et al. 2003). This was a total of three schools in Hackney and thirteen in Newham. See Appendices 14 and15 for teacher information letters. To ensure confidentiality, it was agreed that participating schools would not be identified. Class participation was assigned on the basis of school timetabling, facilitating inclusion of a mixed ability sample of pupils.

7.5.1.1. Assessments within the screening questionnaire for sample selection

The screening questionnaire (Appendix 13) contained age appropriate questions adapted from previous research with adolescents on demographics such as gender, date of birth, household composition and ethnicity (Meltzer et al. 2000;Stansfeld et al. 2003).

Questions on adverse life events and stressors were taken from a combination of previous adolescent studies (Hawton et al. 2006;Stansfeld et al. 2003). Items relating to parental arguments, being in care, continuing money problems, bereavement in the immediate family, parental divorce or separation, illness, injury or mugging of a family member and problematic parental alcohol consumption were from the RELACHS study (Stansfeld et al. 2003). Items relating to problems with a boy or girlfriend, falling behind in schoolwork, being bullied at school and an open-ended question on any other distressing events occurring to close people were taken from the CASE study, included after communication with the CASE study research team. These questions were published (Hawton et al. 2006). Additional items on cultural pressures and expectations from parents/ carers were added to prompt discussion of these issues in the interview. These had been noted as issues potentially important for a sample with a high proportion of young people from minority ethnic groups (Bhugra 2004).

The coping questions were adapted using items from the A-cope (Patterson & McCubbin 1987). This included single item statements about coping strategies relevant to the research questions, as identified from piloting, along with an open-ended question for participants to suggest additional coping strategies. This adapted scale also provided a context for questions on self-harm; identifying different methods of self-harm, and whether they had self-harmed once or repeatedly. Additional relevant items were added to the scale to explore. For example, an item about spending time alone was added as previous research reported that young people who had self-harmed were less likely to talk to someone and more likely to stay in their rooms than young people who had not self-

harmed (Evans et al. 2005). The response options for the scale were changed; including categories of having thought about that strategy, or not, having done it once or more than once, see Appendix 13.

7.5.1.2. Procedure to recruit the interview sample

The procedure using the screening questionnaire prior to qualitative interviews was a multi-stage process. The study procedure is depicted briefly in Figure 6a. See Appendix 6 for a full flowchart of study protocol and participation.

At each school, the process began with Head Teachers being contacted, asked for consent to participate and for a named contact teacher to liaise with about the study. On receipt of consent from the Head Teacher (see Appendix 15), liaison teachers provided the names of pupils in the classes available to be surveyed prior to data collection. All pupils were allocated a unique numeric code.

Pupil information letters and parent opt-out forms were distributed at least one week prior to the survey (Appendices 16-17). Letters and opt-out forms for parents were translated into Bengali, Punjabi and Urdu, the most common languages other than English spoken at home, reported in the RELACHS study. Parental opt-out was used with the aim of being inclusive, as parental opt in may have discriminated against those with literacy problems or those who did not have an understanding of research.

Prior to the school visit, teachers were sent a confirmation letter about the study (Appendix 18) and information sheets to be distributed. Surveys were administered in class groups, during citizenship lessons, registration or lunch breaks. On the day of the survey, pupils were given further verbal information and invited to ask questions, prior to signing to give informed consent, using the form in Appendix 19. The researcher led the class, in accordance with the protocol (Appendix 6), answering questions when required. Class teachers were present, assisting with maintaining exam-style conditions for questionnaire completion.

At the end of each screening questionnaire session, all participants were thanked, given the opportunity to discuss any issues from the questionnaire, and also information about local youth-oriented services and support. One week after the survey the schools were contacted again to invite the selected pupils for an individual interview the following week.

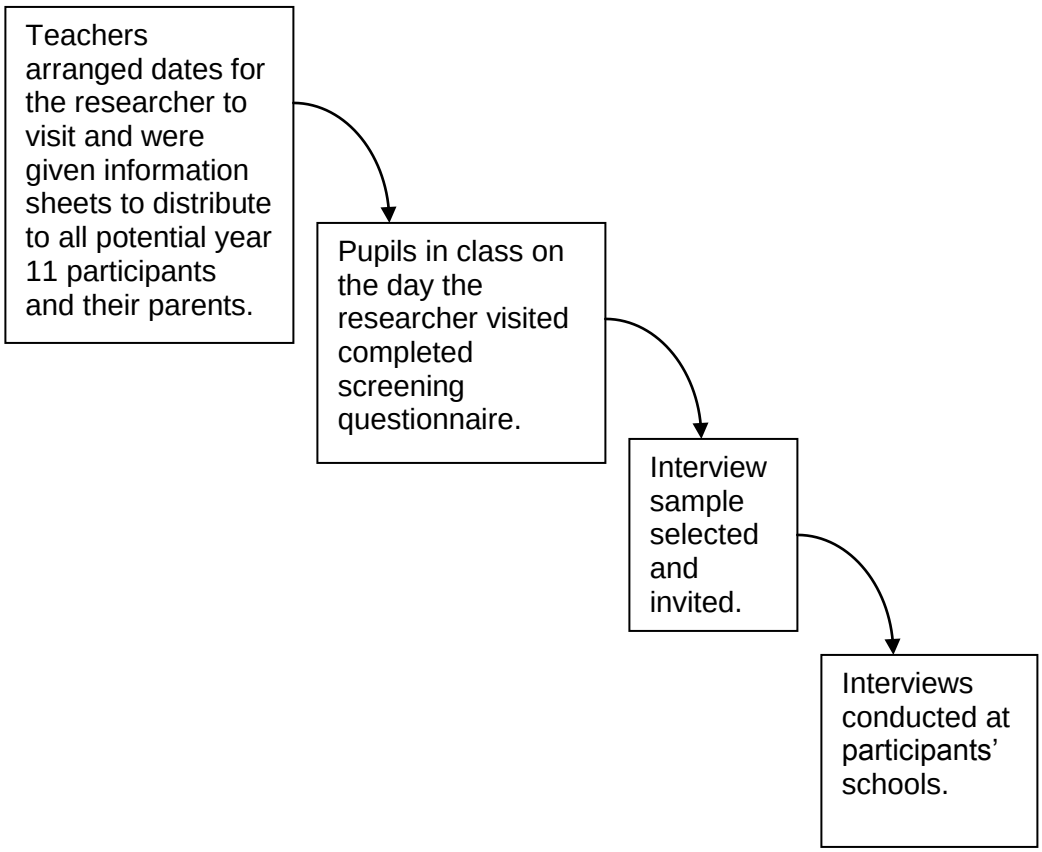

Figure 6a: Procedure for conducting the qualitative study in each consenting school

7.5.1.3. Summary of data used to select interview sample

Descriptive analysis was conducted on screening questionnaire data using SPSS (Version 13). These results will be presented to provide a description of the population from which the qualitative interview sample was drawn. The prevalence of coping strategies and self-harm will also be presented.

Of the sixteen schools invited, four schools participated in the study; one in Hackney, and three in Newham. Three of the schools were single sex (two schools for girls and one for boys), and one school was mixed. Reasons for non-participation at school level included Year 11 pupils having insufficient time (6 schools), schools stating they were not interested in participating (2 schools), or not returning calls or emails (4 schools).

Invitations to participate were distributed to 706 pupils at four schools. If pupils or whole classes were not given the study information, they were not able to participate. Teachers selected classes based on school timetabling when the researcher was available. Not all Year 11 pupils were invited, only those whose classes fell at the appropriate times. The questionnaire was not aiming to survey a representative sample, thus, surveying partial year groups was not viewed as a substantial limitation.

A total of 319 pupils were surveyed; 229 (71.8%) participants were female and 90 (28.2%) were male. The sample included a wide range of ethnic groups, as shown in Table 58. The largest ethnic groups were of Asian Bangladeshi, Indian and Pakistani participants. Participants were aged 15-16 years, with a median age of 15 years 7 months.

Responses to the coping strategies questions are presented in Table 59. Although these data are not representative, they provide some context for the interview data, to be discussed in Chapter 8. More than half of this sample had never thought about talking to a school counsellor, and over 80% had not thought about going to talk to a doctor about stressful times. Over 85% had never thought about taking an overdose, and 75% had never thought about any other form of self-harm.

Table 60 presents the prevalence of overdoses and self-harm reported from closed-response questions in the screening questionnaire. Combining reports of overdoses and other forms of self-harm, this sample had a lifetime prevalence of 15.7% (n=50). The prevalence was higher in girls (18.8%) compared with boys (7.8%), and the prevalence of overdoses was lower than other forms of self-harm. The proportion of people who had self-harmed in some way may be elevated as the sample contained a higher proportion of girls than the third phase of RELACHS, reported in Chapter 5.

Table 58: Screening questionnaire participants by gender and ethnic group.

Ethnic Group	Males		Females		Total	
	n	(%)	n	(%)	n	(%)
White - UK	2	(2.2)	10	(4.4)	12	(3.8)
White - Irish	0		3	(1.3)	3	(0.9)
White - Turkish	0		8	(3.5)	8	(2.5)
White - Kurdish	0		2	(0.9)	2	(0.6)
White -Other	4	(4.4)	9	(3.9)	13	(4.1)
Mixed White & Black Caribbean	1	(1.1)	8	(3.5)	9	(2.8)
Mixed White & Black African	0		4	(1.7)	4	(1.3)
Mixed White & Asian	0		1	(0.4)	1	(0.3)
Mixed - Other	1	(1.1)	7	(3.1)	8	(2.5)
Asian Indian	13	(14.4)	26	(11.4)	39	(12.2)
Asian Pakistani	17	(18.9)	22	(9.6)	39	(12.2)
Asian Bangladeshi	14	(15.6)	37	(16.2)	51	(16.0)
Asian British	5	(5.6)	8	(3.5)	13	(4.1)
Asian Other	3	(3.3)	11	(4.8)	14	(4.4)
Black Caribbean	3	(3.3)	9	(3.9)	12	(3.8)
Black African	9	(10.0)	27	(11.8)	36	(11.3)
Black Somali	3	(3.3)	7	(3.1)	10	(3.1)
Black British	1	(1.1)	6	(2.6)	7	(2.2)
Black Other	1	(1.1)	4	(1.7)	5	(1.6)
Vietnamese	2	(2.2)	0		2	(0.6)
Other	4	(4.4)	7	(3.1)	11	(3.4)
Missing ethnicity data	7	(7.8)	13	(5.6)	20	(6.2)
Total	90	(100)	222	(100)	319	(100)

Table 59: Frequency of coping strategies and risk behaviours from the questionnaire to select the interview sample

Actions taken if stressed or upset	**Never thought about it**		**Thought about it only**		**Done this once**		**Do this occasion-ally**		**Do this often**		**No response**	
	n	**%**	**N**	**%**	**n**	**%**	**N**	**%**	**n**	**%**	**n**	**%**
6.1. Talked to a friend about what was bothering you	38	*11.9*	16	*5.0*	44	*13.8*	107	*33.5*	106	*33.2*	8	*2.5*
6.2. Tried, on your own, to figure out how to deal with your problems	15	*4.7*	16	*5.0*	25	*7.8*	104	*32.6*	149	*46.7*	10	*3.1*
6.3. Spoken to a teacher/ school counsellor	168	*52.7*	48	*15.0*	48	*15.0*	30	*9.4*	9	*2.8*	16	*5.0*
6.4. Taken drugs	266	*83.4*	19	*6.0*	15	*4.7*	6	*1.9*	2	*0.6*	11	*3.4*
6.5. Tried to be funny and make light of it all	86	*27.0*	31	*9.7*	48	*15.0*	87	*27.3*	45	*14.1*	22	*6.9*
6.6. Became angry and yelled at people	61	*19.1*	26	*8.2*	63	*19.7*	92	*28.8*	60	*18.8*	17	*5.3*
6.7. Spoken to a doctor about it	261	*81.8*	26	*8.2*	8	*2.5*	6	*1.9*	3	*0.9*	15	*4.7*
6.8. Drunk beer, wine or spirits	235	*73.7*	14	*4.4*	28	*8.8*	26	*8.2*	4	*1.3*	12	*3.8*
6.9 Drunk more alcohol than you think you should have	264	*82.8*	10	*3.1*	17	*5.3*	9	*2.8*	2	*0.6*	17	*5.3*
6.10. Spent time on your own	31	*9.7*	16	*5.0*	62	*19.4*	107	*33.5*	89	*27.9*	14	*4.4*
6.11. Taken an overdose	273	*85.6*	18	*5.6*	10[¤]	*3.1*	3[¤]	*0.9*	1[¤α]	*0.3*	14	*4.4*
6.12. Harmed yourself in some other way e.g. cut yourself	240	*75.2*	20	*6.3*	24[¤]	*7.5*	16[¤]	*5.0*	4[¤]	*1.3*	15	*4.7*
6.13. Talked to a family member about what was bothering you	92	*28.8*	32	*10.0*	65	*20.4*	68	*21.3*	46	*14.4*	16	*5.0*
6.14. Listened to music or the radio	21	*6.6*	2	*0.6*	18	*5.6*	59	*18.5*	204	*63.9*	15	*4.7*
6.15. Smoked cigarettes	212	*66.5*	22	*6.9*	36	*11.3*	23	*7.2*	12	*3.8*	14	*4.4*
6.16. Done risky things because you didn't care	182	*57.1*	46	*14.4*	42	*13.2*	21	*6.6*	12	*3.8*	16	*5.0*
6.17. Talked to a priest, imam, minister or rabbi	246	*77.1*	27	*8.5*	14	*4.4*	12	*3.8*	7	*2.2*	13	*4.1*
6.18. Emailed or chatted online about it	167	*52.4*	15	*4.7*	31	*9.7*	54	*16.9*	38	*11.9*	14	*4.4*

[¤] These participants were invited for interview, having self-harmed once or more than once. [α] The participant who reported taking overdoses was invited for interview, and later excluded after reporting his survey had been a non-serious attempt.

Table 60: Self-harm and overdose results from screening questionnaire

Frequency of self-harm by method[α]	Females n (%)	Males n (%)	Total n (%)
Never self-harmed	186 (81.2)	83 (92.2)	269 (84.3)
Self-harmed once, never taken an overdose	20 (8.7)	2 (2.2)	22 (6.9)
Self-harmed more than once, never taken an overdose	11 (4.8)	3 (3.3)	14 (4.4)
Overdosed once, no other self-harm	6 (2.6)	0	6 (1.9)
Overdosed once, other self-harm once	1 (0.4)	0	1 (0.3)
Overdosed once, other self-harm more than once	3 (1.3)	0	3 (0.9)
Overdosed more than once, other self-harm once	1 (0.4)	0	1 (0.3)
Overdosed more than once, other self-harm more than once	1 (0.4)	2 (2.2)	3 (0.9)
Total	229 (100)	90 (100)	319 (100)

[α] In this table "self-harm" refers to item 6.12 in the screening questionnaire, distinguishing overdoses from other harm; asking whether participants had "harmed yourself in some other way e.g. cut yourself"

7.5.2. Sample invited for interview

Participants who reported an overdose or another form of self-harm were invited for an interview. These pupils were noted as having self-harmed once, more than once or not at all. The participants who had never self-harmed were selected to explore attitudes in people who had never tried it, and to avoid drawing attention to the self-harm status of those invited for interview. There was no attempt to 'match' participants.

The quota of non-self-harming participants was determined by the number of pupils of each gender who had self-harmed within each school. One person who had not self-harmed was invited for every 1-2 people who had self-harmed. This pattern was followed separately for males and females (see Appendix 6). Pupils who had not self-harmed were selected randomly within gender groups, using their code and a random number table.

7.5.3. Recruitment procedure

Pupils to be invited for an interview were given a personal invitation, including information about the content of the interview, a copy of the consent form they would be asked to sign (Appendies 20-21) and study information and opt-out forms for their parents (Appendix 17). An interview time and location was agreed with liaison teachers for each interview, for example in that teacher's office or an interview room within the school.

7.6. Procedure for individual interviews

7.6.1. Interview procedure; using the topic guide and screening questionnaire

Upon arrival, the researcher re-introducced herself to each paticipant. Participants were given a copy of the written information to read, and asked if they had further questions (see Appendix 6 for interview verbal instructions). Pupils were asked to read through and sign the consent form. They were informed of being free to withdraw from the study at any time, and that their answers would be kept confidential unless they were of particular concern to the researcher.

The participant was then given the copy of the screening questionnaire they had completed, asked to have a look at it again, and for their thoughts about it. This was done with the aim of giving participants a chance to comment on the work the researcher was doing, the questions they had been asked, and giving the participants some power to comment on the process of the research. The screening questionnaire was present throughout the interview, able to be referred to by both the researcher and the participant while discussing issues in the topic guide (Table 61). During the interview, the interviewer aimed to suspend her views to allow participants' accounts to develop (Legard et al. 2003).

Following the tabling of the screening questionnaire, the researcher began working through issues in the topic guide, with a flexible approach, tailored to the responses given by each participant while aiming to explore the issues in the topic guide (Arthur & Nazroo 2003). The topic guide was used loosely, and although it provided some structure to the interview, the topics were not necessarily covered in the same order for each interview. The interview technique included direct "mapping" and "mining" questions to explore relevant topics in some degree of depth (Legard et al. 2003).

Table 61: Topic guide for individual interviews

Topic	**Probes**
• Identity / self image	- physical and social identity - what is important to you - spare time - how others perceive you
• Screening questionnaire	- what is your opinion? *Aiming to give participants a chance to comment on my work before asking more questions*
• Social context	- influences on identity and actions - important people - who do you live with - groups - clothing - spare time
• Stressors	- life events - provoking factors - stressors/ life events from screening questionnaire
• Coping	- what do you do? - perceived options - strategies - attitudes - when angry? Or upset? - Coping strategies from screening questionnaire - ? changing body…? - Role of other people –knowing about what they do, or talking to others
• Self-harm *-> general Qs about self-harm for all participants, Qs on experiences for only those who had self-harmed*	- term “self-harm” – what would that mean to you? - attitudes to self-harm - why might someone do it? - types? - exposure – in the media? - disclosure of harm by others? - their idea of an appropriate response if self-harm was disclosed -> responsibility of the people who have been told?

Topic Guide continued	**Probes**
• Self-harm *-> Qs on experiences for only those who had self-harmed*	*-> if participant has self-harmed* - subjective experience – when? - actions - recollection of reasoning - repetition - perception of severity - feelings before & after - thoughts about stopping - does anyone else know? Who would you tell if you were going to tell someone? Why? What would you tell them? - what would you be looking for if you did tell someone? - if others know – who & what have been helpful? - self-harm and self image
• Social support	- close people - talking to others about personal issues – why / why not? - Expectations of social support - Who to talk to? - teachers? Other professional sources of support?
• Health Risk Behaviours	- *added in during data collection if participants did not wish to discuss self harm* - reasons someone your ages might drink or smoke or take drugs?
• Culture *If this has not been mentioned earlier, it will be covered at the end of the interview. It will not be raised directly earlier in the interview, to see whether it just comes up.*	- If I said 'culture' what would that mean to you? - What defines culture - Own culture - Roles for different groups e.g. gender roles? - Influence of culture on coping with stress (or attitude to self-harm)? - Religion? - Family culture & beliefs? – do you ever disagree about issues relating to culture? - "culture conflict"? - If time: From RELACHS 3 questionnaire: what would you tick for the questions about cultural identity and clothing? What do you think it might mean to tick low on the family clothing identity with your own race or ethnic group, and high or low on the other race / ethnic group for clothing with family
• Plans for the future	• Your plans – this year, end of secondary school & in five years Your family's plans for you
• *Is there anything else that you feel I should have asked, or you would like to add?* • *How did they find it talking to me about those issues?*	
• Explore the possibility of expressing some of the ideas about coping or self harm in other ways – like poetry or artwork - & ask if they would be willing to share those with the researcher.	

All participants were invited to tell the researcher about themselves. Open questions such as “Can you tell me a bit about what you like doing with your time?”, with probes potentially including questions about time spent in school, outside of school, alone, or in company of others. The researcher probed with questions about their interests, who they spent time with, whom and what were important to them, as a means of introduction and to open the conversation about perceived identity and social context. Through the course of the interview, participants were asked to explain what sorts of things they were finding difficult at that time, what made them angry or upset, how they dealt with those feelings and their experiences of talking to others and seeking help.

The interviews were conducted sensitively, and if participants were not comfortable talking about their experiences, they were not pushed to do so. Conversely, if participants wished to talk about a certain issue in more detail, they were encouraged to do so.

The interview was tailored to suit the responses provided by each participant. The researcher aimed to allow participants to introduce the issues of self-harm and culture into the discussion of social context, stress and coping, if they felt those issues were relevant. If definitions and use of “self-harm” and “culture” had not arisen within the course of the interview, participants were asked for their interpretation of those terms. This was done in order to clarify how the participants used that terminology, to ascertain if their use of such language differed from the way that the researcher was using them (Britten 1995). The researcher prompted discussion of these topics with questions towards the end of the interviews, if they had not already been raised, or to clarify references to culture and to coping strategies of a self-destructive nature.

During data collection, there was reflection on the material arising in the interviews and the research process; particularly the difficulties encountered when exploring the topic of self-harm with these participants. Interviews conducted later in the data collection included more in-depth questions about themes emerging from earlier interviews, particularly relating to disclosure of self-harm and other “risky” or experimental behaviours. All interviews concluded with a discussion of the participants’ social support and aspirations. Participants were debriefed by the interviewer, offered time to discuss any issues arising, given information about local youth-oriented services and school-based support.

The sensitivity of the topic was acknowledged, and the interview style tailored accordingly (Alty & Rodham 1998;Legard et al. 2003;Liamputtong & Ezzy 2005). In order to informally gauge the impact of the interview, participants were shown a visual analogue, adapted from the EuroQol questionnaire (EuroQol Group 1990), as used by suicide researchers from the University of Bristol (L.Biddle, personal communication). Participants were asked to rate their current emotional feelings, from “feeling amazing” to “feeling awful” on a scale from 0 – 100, with the focus on their mood, rather than their physical health. This assessment was included to ascertain how the interview affected participants and to provide some data relating to the concerns raised during the process of obtaining ethical approval. All interviews were recorded with an Olympus DM-20 recorder.

7.7. Analysis

All interviews were transcribed by a medical secretary with experience of transcribing research interviews. The data was stored in Microsoft Word and Excel for analysis using the approach taken by framework methodology, developed by the National Centre for Social Research. The steps involved have been outlined below (Ritchie et al. 2003b;Spencer et al. 2003).

7.7.1. Framework analysis

Framework is a matrix-based approach to data analysis, facilitating comparison between participants and within individual accounts (Ritchie et al. 2003b), enabling the whole dataset to be analysed together. Data analysis comprised of multiple stages; involving data management, identification of broad themes, charting of data while refining the themes, and interpreting the data in terms of descriptive and explanatory accounts (Ritchie et al. 2003b;Spencer et al. 2003).

Data management is a form of preliminary analysis and involved becoming familiar with the data, charting the emerging themes and sub-themes from within the interview content. In order to conduct the analysis, the doctoral student made notes after each interview. She listened to the interviews, read and re-read the transcripts to immerse herself in the accounts given by the participants.

Each column contained a theme or sub-theme and each row contained data from a different participant. The charts were developed from the data, which reflected topics within the topic guide and issues arising in the interviews. Charting maintained the concepts and language used by the participants, while summarising the data from full transcripts; mapping out the breadth of the topics explored. Data was charted if it was of particular relevance to the research objectives, if it was particularly important to a participant, or recurring across accounts.

Data organisation, initial analysis and charting set the foundations for progression to analysis at a deeper level. Thematic categories developed and became more defined as the charting progressed; encompassing the meanings attributed by participants to different factors being explored, revisiting and building on earlier analysis. Transcripts were revisited when issues arose clearly in later interviews, to check whether they had also been evident in earlier interviews. The ideas explored were built up through the process of analysis, looking at issues across and between cases.

Eight charts were made from the interview data in this study. The charts were titled:

(i) Sense of self
(ii) Social context and influences
(iii) Culture
(iv) Stress and stressors
(v) Responses to stressors
(vi) Self-harm
(vii) Help-seeking and service provision for self-harm
(viii) Social support and communicating with others when distressed

Appendix 22 presents the sub-themes for each of these charts. An extract from the self-harm chart used in this study is presented in Appendix 23, showing the 30 rows, one for each participant and an example of seven columns of interview data.

Following the identification of themes and sub-themes, and complete charting of the data, the process of analysis moved to data interpretation. This was achieved through the process of collating and mapping out of emergent ideas and patterns from within the data; interpreting meanings into descriptive and explanatory accounts (Ritchie et al. 2003b). Descriptive accounts were used to understand the breadth of the data; exploring the variation in accounts, how they were presented and what participants considered relevant when describing an aspect of an issue, such as self-harm. These were developed into

explanatory accounts where data were of sufficient depth to propose mechanisms for why patterns occurred (Ritchie et al. 2003b;Spencer et al. 2003). The development of descriptive and explanatory accounts involved checking and revisiting the data and charts to refine and develop ideas throughout the process. This enabled the research to function as both “contextual” and “exploratory” (Ritchie 2003).

The focus of this study was on exploring accounts presented by participants, that is, how these young people explained their views and experiences. Given that premise, the analysis relied primarily on how the young people explained their behaviour, with some interpretive input from the researcher in identifying emergent patterns and variation. The contents of individual experiences were varied, despite being framed within the loose structure of the topic guide.

The methodology employed aimed to distinguish meanings and attitudes from actions. Explanations given within the interviews were used as a means of unpacking the participants’ reasoning, as opposed to attempting to fit the data within a set of pre-conceived concepts.

7.7.1.1. Quality of the research and methodological rigour

Methodological rigour is important in qualitative research, demonstrating adherence to consistent approached, and transparency in reporting the research (Liamputtong & Ezzy 2005;Silverman 1985). Guidelines provide some criteria against which to assess qualitative research (Lewis 2003;Liamputtong & Ezzy 2005;Mays & Pope 2000;Pope et al. 2000). This chapter has provided an explanation of the methodology employed to justify the credibility of the study. While aiming to maintain neutrality and objectivity, a part of this analysis will include reflexivity; noting possible bias introduced by the researcher in the interviews, analysis and interpretation (Ritchie et al. 2003b), discussed in Chapter 9.To increase the interpretative rigour, the charts were validated by an experienced qualitative research colleague (MK) who read a sample of 3 transcripts (10%), checking the charting and thematic category development. Further critique of the methodology is presented in Section 9.3.2.

8. Qualitative study results

8.1. Introduction

The previous two chapters presented the pilot study and methodology for this qualitative study. This chapter begins with a description of the interview participants, and then goes on to outline their attitudes to and experiences of self-harm. Sections will be structured in accordance with the aims. Section 8.3 presents attitudes to self-harm, Sections 8.4 and 8.5 will describe the variation in personal experience of self-harm and Section 8.6 will address the issues of disclosure and seeking help. In order to provide some context for disclosure of self-harm, a brief outline of participants' social context will be presented, followed by a description of their views on talking about personal problems in general. Ethnicity and culture will be discussed where participants made reference to them when discussing self-harm. Quotes will be used to show evidence and participants will be identified by their participant number (See Table 62), age, gender, ethnic group and self-harm status.

Length of interviews

Interview times were dictated by the length of lessons (depending on the school), and when the participant arrived at the room where the interview was conducted. The mean interview time was 39 minutes, with the longest interview lasting 66 minutes, and the shortest being 17 minutes long. The interview times refer only to the recorded interviews, and thus do not include the time taken to answer questions about the study and when the participant gave their consent to participate.

8.2. Participants

The final interview sample is shown within the context of the screening questionnaire procedure in Figure 6b. This figure presents the self-harm status reported in the screening questionnaire and the interview, as there was variation between the two assessments. The final interview sample is described in Table 62, showing participant number, gender, age and ethnicity. There were 30 participants in total; ten had never self-harmed (P1-P10),

nine had self-harmed once (P11-P19) and eleven had self-harmed more than once (P20-P30).

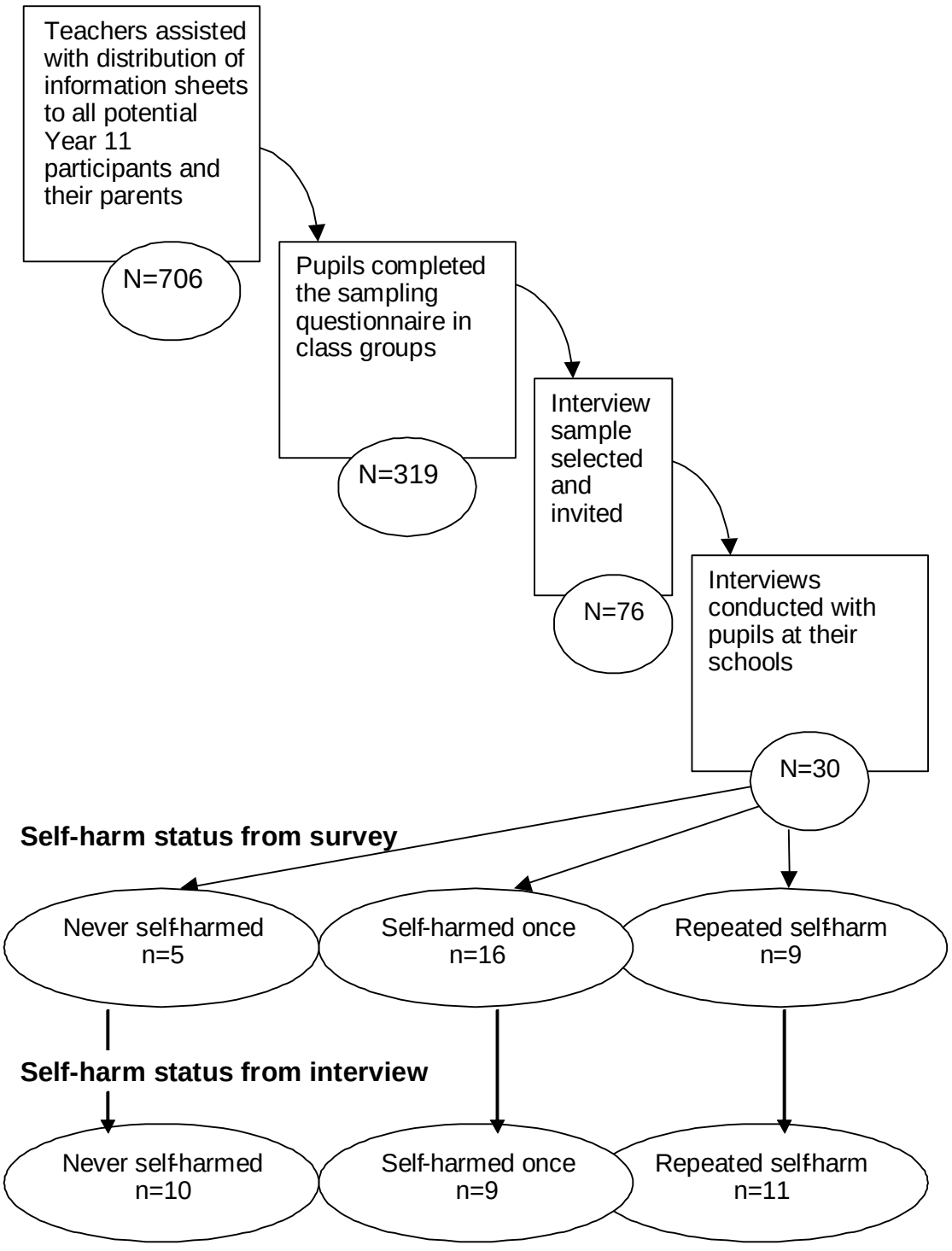

Figure 6b: Sampling and self-harm status of qualitative study participants

Table 62: Final interview sample for qualitative study

Participant number	**Has never self-harmed (P1-P10)**	Participant number	**Has self-harmed once (P11-P18)**	Participant number	**Has self-harmed more than once (P19-P30)**
	Gender, age, ethnicity		***Gender, age, ethnicity***		***Gender, age, ethnicity***
P1	Female, 15, White-Irish	**P11**	Female, 15, Black African & Asian	**P20**	Female, 15, White Turkish
P2	Female, 15, White-UK	**P12**	Female, 15, White Irish & Welsh	**P21**	Female, 15, White & Oriental Asian
P3	Female, 15, White & Black African	**P13**	Female, 15, Mixed White UK, Irish & Black Caribbean (Jamaican)	**P22**	Female, 15, Asian Indian
P4	Female, 15, White & Black African	**P14**	Female, 15, Asian Pakistani	**P23**	Female, 15, Asian Sri Lankan Tamil
P5	Female, 16, Asian Bangladeshi	**P15**	Female, 16, Asian Bangladeshi	**P24**	Female, 15, Asian Bangladeshi
P6	Female, 15, Black Somali	**P16**	Female, 15, Asian Bangladeshi	**P25**	Female, 15, Black African
P7	Female, 15, Black African	**P17**	Female, 15, Asian Bangladeshi	**P26**	Female, 15, Black Somali
P8	Male, 15, Asian Bangladeshi	**P18**	Female, 15, Asian Bangladeshi	**P27**	Female, 15, Black British
P9	Male, 16, Black African	**P19**	Female, 15, Black British	**P28**	Male, 15, Pakistani & Asian British
P10	Male, 15, ethnicity not given			**P29**	Male, 15, Asian Pakistani
				P30	Male, 16, Asian Indian

There were no formal pupil or parent opt-outs for interviews. Liaison teachers played a central role in delivering interview invitations and arranging the interview timetable. This implies the possibility of teacher opt-out, which may have been intentional or circumstantial, if a teacher was not able to deliver the pupil invitation. If pupils did not attend the scheduled interview it may have been a pupil opt-out, or their teacher not letting them out of class.

8.3. Perceptions of and attitudes to self-harm

This section presents an outline of general conceptualisations of and attitudes to self-harm. This includes both exposure to and personal experience of self-harm, which informed young people's views.

Assessment of lifetime self-harm in the screening questionnaire facilitated the inclusion of participants who currently hurt themselves, and also people who had not self-harmed recently. Participants who felt their self-harm was behind them held similar views, irrespective of the number of times they had self-harmed. This differed from the wider range of views reported by those who had hurt themselves more recently. That is, the timing of their harming behaviour influenced their views, as well as the number of times they had hurt themselves.

Participants' explanations suggested that self-harm was not a unitary concept. Some participants held a range of views on self-harm, acknowledging that it may encompass a variety of behaviours and mean different things at different times. Some viewed their own harm as different to self-harm in others, or expressed a change in their attitudes to self-harm over time. Differences in motivations and precipitants of self-harm will be presented in Sections 8.4 and 8.5.

8.3.1. What is self-harm?

Most participants gave a clear definition of "self-harm" relating to some form of self-injury; including cutting themselves, slitting wrists, taking tablets or an overdose. Other descriptors of self-harm included not eating (P25), hitting one's head against a wall (P16), pinching (P13, P22), burning (P26) as well as body piercing and tattoos (P21). Two participants who had not self-harmed made reference to the possibility of people

'emotionally' self-harming, by putting themselves down (P1), stressing themselves or worrying a lot (P6). Emotional harm was not mentioned by any participants who had physically hurt themselves.

8.3.1.1. Punching walls

The study definition of self-harm was purposefully broad, with the aim of capturing the potential breadth of the topic. This led to the inclusion of young people who had repeatedly punched walls as part of the self-harming sample. In the interviews, six participants mentioned punching hard surfaces to feel pain, get bruises, express anger or frustration (P8, P20, P21, P26, P28, P30).

> *"I just punch stuff, innit? Like punch everything around me and then I get scars."*
> *(P28, Male, 15, Pakistani & Asian British, line 152, had self-harmed more than once)*

The males who punched walls did not relate the term 'self-harm' to their own actions. A 15 year old girl who had previously cut herself reported that she now punched things as an "easier" way of dealing with her anger. She saw her cutting as self-harm, however punching things was not self-harm as she did not need to hide it (P21). These comments imply that punching a wall may be a socially sanctioned way to express anger. However, by virtue of it being a self-initiated injury functioning to release emotion, it fits within the definition of self-harm adopted for this study. It was also viewed as self-harm by some of the participants.

8.3.1.2. Severity of self-harm

Both those who had and had not hurt themselves observed that self-harm could vary and potentially escalate in severity (P6, P12, P21, P26, P27). Of those who had, most were keen to clarify that their own harm was not as severe as that done by others (P12, P21, P26, P27). This may have been the case, or an indication of stigma about self-harm. Variation in severity related to the potential danger in the method used (P12, P21), and whether or not the person was in control of their self-harm (P21, P26, P27).

> *"…it depends because if it gets so bad that you are sort of harming yourself in a way that's sort of irreversible, like literally cutting so deep that it affects you, like it sort of affects your writing or it affects something else in your life then that, I think, is serious and that should be dealt with. But if it's like sort of surface scratches and it's just like once every couple of months or something, then it's not really a problem and you're not really thinking about it all the time, as sometimes it can consume you completely."*
> *(P21, female, 15, White and Oriental Asian, line 323, had self-harmed more than once)*

8.3.1.3. Deliberate and accidental self-harm

Interpretation of “self-harm” included self-inflicted, accidental harm. For example, one participant reported overdosing by taking a catch-up dose of prescribed medication after missing a previous dose (P6), implying accidental self-harm, without emotional involvement or self-destructive intent. This raises the issues that some emotional component may be relevant when distinguishing between deliberate self-injury and accidental injury, such as falling off a bike. However, two participants suggested, people may choose to have an accident as a form of self-harm (P7, P14). However, emotional motivations for self-harm were not reported by all participants; two of the males who had repeatedly self-harmed claimed that it was just something to do (P28, P29) with "*not much to it, really*" (P29, line 134). Intentions when self-harming will be discussed further in section 8.5.1.1.

8.3.2. Attitudes to self-harm

This section will describe attitudes to self-harm and justifications given for those views. Attitudes were intermingled with the participants’ own harming experiences and perceived reasoning behind it. The majority of participants held negative views about self-harm which often related to difficulty in understanding the behaviour. This was evident in people with and without personal experience of self-injury. Some participants implied that self-harm was more understandable if the reasoning behind it was known and deemed valid (P4, P27). For example, self-harm was presented as a response to a one-off crisis (P11, P19, P27), a response to ongoing feelings of distress (P14, P22, P29), anger (P26, P30), or a need to feel strong (P28). It was also depicted as a phase or something to try out when feeling low (P4, P21).

> *“another thing about self-harming, you don’t really know who’s doing it. Generally whether it’s like a proper... personal issues or if it’s someone who’s just being ... like stupid.” (P3, female, 15, White & Black African, line 156, had never self-harmed)*

Whereas most participants simply gave their own opinions, others justified their views with reference to religion. Two participants noted that self-harm would be unacceptable for all religions, not only within their own Muslim belief system as it “*shows you’re not grateful of what you have and everything*.” (P26, female, 15, Black Somali, line 306).

The majority of participants who had not self-harmed expressed disparaging views about the behaviour. These participants explained that as they had not self-harmed, they did not understand it. Some of their views related to the physical aspect, saying "*It's disgusting*" (P7, line 326). Others described it as "*dumb*" (P9, line 232) or *"the stupidest thing ever"* (P6, line310). These young people also commented that they may think differently if they had had other experiences (P1, P2, P7, P6).

> *"But then again, I'm not in that person's shoes. So I can't speak on behalf of that person. I don't know what that person's going through."*
> *(P1, female, 15, White-Irish, line 312, had never self-harmed)*

Negative views were also expressed by participants who had self-harmed. Comments from people who had hurt themselves once included it being unhelpful (P15), or something that people should not do (P18, P19). This negative view extended beyond their own harm to include harm talked about by friends. Acknowledgement of the potential danger of self-harm heightened the negativity from some participants (P12, P20, P21, P26).

> *"It kind of made me want to say stuff to them, like, how they're being silly, stupid, and how they shouldn't do it because it's dangerous, and stuff like that, because they could like bust a vessel" (P12, female, 15, White Irish & Welsh, line 144, had self-harmed once)*

> *"I just find it stupid and just, dumb ... I just can't believe I done that!"*
> *(P26, female, 15, Black Somali, line 258, had self-harmed more than once)*

Most participants who had self-harmed once described a sense of distance from that experience at the time of the interview. Some saw it as something they never thought they would do and would not do again (P14, P17), while others expressed wariness as it was easy to do (P11, P17). Participants who perceived a distance from their own self-harm emphasised there being no reason to self-harm, and wondering about their actions at the time (P7, P11, P16, P25, P26, P27). Those who had repeatedly self-harmed and had ceased harming, reported that it had seemed like a good idea at the time, but was behind them, and they no longer related to self-harm (P20, P21, P23, P26, P27).

> *"I don't see it as wrong, but I see it as something that ... that is pointless; there's no need to do it." (P21, female, 15, White & Oriental Asian, line 265, had self-harmed more than once)*

> *"I sort of hung around with a crowd that thought that self-harming was cool as well, and I thought that that was ridiculous at first, but... I mean, and even while I was doing it, I didn't find it cool." (P23, female, 15, Asian Sri Lankan Tamil, line 400, had self-harmed more than once)*

There was some stigma around self-harm, with perceptions that it was about attention-seeking. Half of the people who had not self-harmed commented that self-harming was about attention-seeking, and were reproachful in their discussion. Eight people who had self-harmed believed others would not understand, approve, or would assume it was about seeking attention. This fuelled their desire to keep it private.

> *"If it's a serious reason then it can be understandable. If it's just ... for attention then ... well, it's just silly." (P27, female, 15, Black British, line 328, had self-harmed more than once)*

Two of those who had repeatedly self-harmed acknowledged that they were looking for a response from other people. Those participants were neither apologetic nor proud of that element of their harm, simply describing their experiences.

8.3.2.1. Exposure to self-harm which informed attitudes

Attitudes about self-harm stemmed from exposure to both real and fictional representations of self-injury. All female participants were familiar with the concept of self-harm. Exposure included knowing or hearing about someone who had self-harmed, having done it themselves, or heard talks at their school. Participants who had spoken with others about self-harm prior to their interview showed more insight than those who had not.

> *"I don't know, it's just something you just know about"*
> *(P2, Female, 15, White-UK, line 246, had never self-harmed)*

The male participants reported less exposure to self-harm. Three of the six boys interviewed had no comment about "self-harm", saying that the term meant nothing to them beyond basic descriptions of what they thought it might involve. Exposure to self-harm influenced participants' attitudes in a variety of ways; increasing awareness of self-harm, normalising it or potentially making them more curious about it. However, exposure did not necessarily increase understanding about self-harm.

> *"she was just like saying, erm, "No, it helps, it helps." And I'm like, "No, it doesn't." That's what she was saying, she said it helps them... but I can't understand how it helps."*
> *(P15, female, 16, Asian Bangladeshi, line 432-3, had self-harmed once)*

The notion that self-harm was something to "try out" was mentioned by participants who had and had not hurt themselves. Exposure as a trigger will be discussed in section 8.4.2.4.

8.3.3. Suicidal ideation

Suicide was not linked with attitudes to self-harm for the majority of participants. The relationship between suicide and self-harm was not a comfortable topic for participants and thus was not probed deeply. Two participants implied suicidal ideation when recounting overdoses, however they did not relate those experiences with the cutting self-harm they knew of in others (P17, P19). Experiences of suicidal thoughts during self-harm will be discussed in section 8.5. Two other participants were clear that there was no point in killing yourself if the problems could be solved (P9, P14). Suicide and self-harm were linked when participants discussed religious views. Disparaging comments were made about people attempting suicide by people who had not self-harmed.

> *"I think if you're going to do it, yeah, do it properly, yeah? If you ... if you really want to hurt yourself, die or whatever, then just do it, yeah?"*
> *(P3, female, 15, White & Black African, line 150, had never self-harmed)*

> *"in my religion it says like you're not supposed to like self-harm yourself, because it's just you're doing it to yourself, it's like committing suicide. It's not the same thing, but you know what I mean?" (P26, female, 15, Black Somali, line 296, had self-harmed more than once)*

8.4. Context, triggers and immediate precipitants of self-harm

Specific triggers, in a context of ongoing stressors and emotions precipitated self-harm. Some participants attributed self-harm to internal factors, explaining that feeling down led them to self-harm. Others described ongoing situations or specific incidents as triggers for their harming, attributing self-harm to external factors. However, most participants detailed a combination of both feelings and events. For example, one 15 year old girl attributed her initial harm to feelings of anger and weakness in the context of ongoing family problems, and specifically triggered by receiving some shocking news (P25). Although feelings and situations were often related, they will be presented separately; the range of feelings will be outlined, followed by the types of situations these young people associated with their self-harm.

8.4.1. Feelings prior to self-harm: internal attributions

The feeling most commonly described as preceding self-harm was anger. It was emphasised by six of the nine participants who had self-harmed more than once, and three of those who self-harmed once only. Self-harm functioned to relieve or release anger

(P14, P15, P20, P22, P25, P26, P27, P28, P30). Two of the boys were particularly aware of their struggle to control anger, whereas the girls spoke more about choosing to keep their anger to themselves. Some viewed self-harm as the only thing to do when angry (P21, P26, P28, P30) while others described a feeling of desperation which pre-empted self-harm (P17, P18*)*. Participants who had never hurt themselves also related emotional expression to self-harm; suggesting it may involve taking anger out on oneself, shock, or simply leading to feeling better (P1, P7).

> *"I'm a very angry person, right. I try to control my anger, but I've been controlling it since two years, to be honest. Before that I didn't. Just ... just ... I can't control it like. When I get angry, I just get angry and I try to stop it, but then I realise what I've done after." (P28, male, 15, Pakistani & Asian British, line 120, had self-harmed more than once)*

> *"It's like a way of getting your emotions out, it's focusing on something else, other than what's sort of making you angry. " (P21, female, 15, White & Oriental Asian, line 159, had self-harmed more than once)*

Some participants self-harmed when they were not able to express themselves in any other way (P11, P13, P29) and described a need to "feel" something other than distress. There were references to frustration, feeling upset and having the desire to release stress (P21, P25, P29). One participant who had repeatedly self-harmed maintained that he did not know why he first did it (line 142), then recounted a range of motivations for later self-harm (P29, line 198).

> *"Sometimes I would do it, like, more if I was angry or something to let my frustration out. Sometimes I would do it just for the fun of it." (P29, male, 15, Asian Pakistani, line 194, had self-harmed more than once)*

Participants who self-harmed reported feeling badly about themselves (P19, P22, P23, P25). This self-depreciating attitude was often reflected in how they thought others saw them, for example, thinking others were disappointed in them (P23), saw them as "bad" (P22), or not good enough (P25).

8.4.1.1. Feeling restricted

Although feeling inhibited by limitations set by authority figures may be a normal element of adolescence, some participants clearly related this claustrophobic sense of restriction to their self-harm. Pressure to perform, conform, or maintain appearances may have

influenced their actions. Part of this restriction related to household circumstances, with some young people reporting that they literally had no space to themselves at home (P15, P17, P19). For others, the sense of restriction related to interpersonal relationships; friends, the wider community and particularly family. The role of the community was noted by people of, for example, Bengali, Pakistani and Turkish backgrounds (P14, P17, P20). Despite living in a densely populated urban area, participants' sense of community related only to people of their own backgrounds, or in contrast to other groups. The role of culture centred on guidelines and expectations from families and community.

> *"Because where we live is like a small village and everybody sees what you do and, you know, hears, you know, what you say." (P20, female, 15, White Turkish, line 388, had self-harmed more than once)*

> *"I think in the white community ..."* (EK: Uh huh.) *"the children are allowed to go outside if they're angry or they just can go outside and just calm their selves down. Whereas in the Asian community, like, maybe a boy can go outside, whereas a girl would be limited and they have to stay at home. And it's kind of hard for me, because I don't have my own room, so I can't go and sit on my own; there's going to be always somebody there, so it's kind of hard to just get rid of your stress and it just all piles up on top of you."*
> *(P15, female, 16, Asian Bangladeshi, lines 297- 305, had self-harmed once).*

8.4.1.2. Feeling distressed

Four participants referred to poor mental health when explaining their self-harm. Participants who had more input from services seemed more accepting of mental health problems, with references to their period of harming being "mad" (P20) or part of a breakdown (P14, P17, P29). Although depressive symptoms were described, most participants did not equate such feelings with mental illness. Others portrayed their own self-harm as unlike self-harm initiated by psychological problems (P15, P16, P21). Mental illness was depicted as an explanation for self-harm, with opinions stemming from personal experience, or fictional representations, such as a "crazy" person one participant described self-harming in a movie (P8).

> *"Sometimes people just do it for no reason, they just feel like doing something just … the brain, like something just telling them to do it for no reason"*
> *(P7, female, 15, Black African, line 338, had never self-harmed).*

> *"Everyone was just thinking, oh, this girl's nuts! Because I was just saying everything, I was just ... oh, talking a lot of bullshit! So ... I was saying things, like, "Oh, no-one cares about me. What's the point? Let's go to hell. Because I felt like I had Satan in me."*
> *(P17, female, 15, Asian Bangladeshi, lines 530-532, had self-harmed once)*

8.4.1.3. Suicidal ideation and looking for a way out

Suicidal ideation was mentioned indirectly by six respondents. Although participants did not use the word “suicidal”, they implied ideation through references to dying or statements such as, *“I didn’t feel like I needed to be in the world”* (P19, female, 15, Black British, line 220). Comments about being suicidal often related to realisations about what they had done afterwards. That is, that if you self-harmed in a dangerous way, there was a risk of dying (P12, P17). Some acknowledged with hindsight that they may have actually been suicidal.

> *“You don’t see the point of living when you’re upset, it’s like, I don’t know, it’s confusing” (P11, female, 15, Black African & Asian, line 258, had self-harmed once).*

> *“I felt as if I needed a way out, but I couldn’t find one and it was like I was looking for the light at the end of the tunnel, but I couldn’t find it because it was so dark everywhere.” (P14, female, 15, Asian Pakistani, line 152, had self-harmed once)*

Suicide was discussed more frequently by those who had self-harmed once, compared with those who had self-harmed repeatedly. Only one person who had not self-harmed acknowledged suicide as a potential motivation (P3). Those who had repeatedly self-harmed may not have wished to link their actions with suicide, being in denial about the potential lethality. These young people may not have been comfortable with the feelings they had at the time of their self-harm, or describing them in the interview.

8.4.1.4. Wanting pain from self-harm

In contrast to the difficulty of discussing suicide, participants talked openly about their desire for pain. This was only expressed by young people who had self-harmed repeatedly, illustrating positive reinforcement from the pain and their previous self-harm (P25, P26, P28, P29, P30). Some appreciated that their self-harm evolved in some way, and had potential to continue a malignant escalation into an all-consuming, dangerous harm (P21, P25, P27).

> *“I’ve, like, built myself to think when something’s wrong, pain is the answer to that problem sort of thing.” (P25, female, 15, Black African, line 114, had self-harmed more than once)*

Some participants described self-harm as self punishment; for having unacceptable feelings, feeling angry (P20), blaming themselves for family problems (P27), or giving themselves further punishment having been rebuked by others (P22).

8.4.1.5. Looking for a response

Attention-seeking or using self-harm as a cry for help was apparent in two accounts. A 15 year old Turkish girl (P20) described cutting herself and bleeding in front of her brother. Another participant couched his account of self-harm in terms of wanting to show others. He explained having problems expressing himself, and knowing that he would receive help after cutting himself. This example is discussed further in section 8.6.2. Attention-seeking was tabled by participants who had not self-harmed, along with the suggestion that it was done for the buzz, to be silly or to show off (P6, P3, P8).

8.4.1.6. Keeping feelings to themselves

Participants keeping feelings to themselves had two components. One related to their own desire to contain their feelings, and the other related to a perceived isolation and lack of support from others. Participants did not wish to take their feelings out on anybody else. For example, not wishing to burden others or increase family stresses (P13, P19, P27).

> *"Like I wouldn't have to self-harm myself in order to sort things out, I could just talk to somebody about it." (P13, female, 15, Mixed White UK, Irish & Black Caribbean, line 190, had self-harmed once)*

Having nobody to talk to frequently preceded self-harm (P13, P17, P22, P25). Parental illness, arguments or "family problems" functioned to remove support, despite the situation increasing the need for it increasing (P11, P13, P17, P22, P25). Whereas some described difficulty in expressing themselves as the main problem, others felt the people around them were unavailable or unlikely to listen (P13, P15, P17). Relationships with others precipitating self-harm will be discussed in section 8.4.2, and the influence of social context on disclosure will be discussed in Section 8.6.

> *"Because there's no-one ... your voice isn't heard, you're just ...* (EK: Mmn?)… *It's, like, you're dying inside." (P17, female, 15, Asian Bangladeshi, lines 492-494, had self-harmed once)*

Rejection and isolation were common themes described during the time when participants self-harmed. For some, it was a general feeling of isolation, that nobody cared or understood (P17, P20, P29), not being liked (P22), or needed (P19). Mixed feelings towards family combined a sense of duty with resentment. For example, some felt that although their parents provided for them materially, they were not emotionally supportive (P11, P20, P29).

> *"It's like all the emotions like at once, and you ... and you realise that the people who are meant to be there for you are not. So for me, it was my mum…"*
> *(P11, female, 15, Black African & Asian, line 244, had self-harmed once)*

Feeling isolated from peers and being bullied was described by participants who had and had not self-harmed (P10, P12, P18, P20, P22, P26, P27, P30). Six participants who had self-harmed made reference to bullying, a form of rejection and antagonism from peers (P12, P20, P22, P26, P27, P30). Bullying functioned to intensify other difficulties they faced, reinforcing negative feelings they had about themselves, rather than a specific trigger for self-harm.

8.4.2. Situations & relationships as triggers: external attributions

The majority of participants accounted for their actions in terms of the people around them and situations they faced. Examples encompassed a range of situations and relationships, implying that if they felt vulnerable, many types of exacerbating circumstances could function as triggers. There was no depiction of any 'required' precipitants. Three participants who had overdosed once referred to taking pills from their home, implying easy access to medication as a factor leading to their self-harm (P15, P17, P19).

8.4.2.1. Social context

The majority of situational accounts for self-harm related to participants' families, with fewer references to peers. These included general 'family problems' (P11, P14, P20, P25, P26, P27) and specific incidents, such as illness or trauma involving a family member. There was some reference to peers; either conflict with people at school, or being exposed to other people self-harming. One participant mentioned troubles with a boyfriend,

compounded by family stresses and knowing that her family would have disapproved. She described having “a breakdown” while giving a presentation on Romeo and Juliet as she felt as though she was talking about herself, rather than Juliet’s character (P14).

As well as providing a sense of restriction for some participants, the “community” was also mentioned as providing a context, exposure and even acceptance of violent behaviours, which in turn, may have influenced self-inflicted violence (P6, P17, P30). Participant P30, a Bengali boy, described his wall-punching in the context of being a violent person. His extreme anger and sense of identity were closely linked as he described moving from being the victim of bullying to the aggressor. Although he took responsibility for punching walls, owning the actions, his justification for it was couched in his relationships with others.

> *“It’s the way I’ve been brought up; not by family or anything. It’s just the way I was ... because I’ve lived in (area) since I was a young person.* (EK: Uh-huh) …*and, it’s like I used to get bullied every day when I used to go ... I used to get beaten up every day by black boys and skinhead white boys, yeah?” (P30, male, 16, Asian Indian, lines 420-422, had self-harmed more than once)*

Despite strongly identifying with the Asian community in his area and justifying his own violence as self defence, he talked of not taking religion seriously, and did not condone violence in the name of Islam. For this participant, harming others and harming himself were triggered easily, seen as very similar, and both would make him feel stronger.

> *P30: I feel like doing something bad. But then, I don’t know, when I hit something ... I have to hit something hard so I can ... I know that I’ve done something.*
>
> EK: Mmn? Can you explain that to me a bit more?
>
> *P30: Like, if I was to hit a teddy bear or something, I’ll ... I will get even more angry because I’m not hurt or neither is he hurt.*
>
> EK: Right.
>
> *P30: But if I hit a wall, I know I’ll hurt myself.*
>
> EK: Right.
>
> *P30: You know? Yeah, and that’s good, to hurt something.*
>
> EK: Why is it good to hurt yourself, do you think?
>
> *P30: I don’t know. I feel much better when I do it.” (male, 16, Asian Indian, lines 274-282)*

8.4.2.2. Interpersonal conflict

Conflict between other people close to the participants, primarily family members, was a common factor preceding self-harm (P11, P13, P14, P17, P25, P27). Five participants specifically mentioned their parents arguing or separating. One participant spoke of self-harming as she did not have any control over the situation at home, despite trying to give her input (P27). Two participants spoke of the wider community putting pressure on their family in terms of reputation (P14, P25). However, there was no consistent pattern about pressure from the community across or within ethnic groups.

> *"My parents, because the culture and everything, even though they're unhappy with each other, they'll still stay together.* (EK: Uh-huh) *Because they don't want a divorce, it puts shame on the family and things like that, sort of thing. But, I find that kind of selfish, because them staying together means more arguments and more things going wrong."*
> *(P25, female, 15, Black African lines 317- 319, had self-harmed more than once)*

In addition to conflict between others, conflict directly involving participants was clearly stressful as well. Arguments with parents and siblings were noted as triggers for self-harm (P11, P16, P22, P23). These were compounded by feeling pressure from the family about how they behaved (P14, P17, P25). For some, conflict with friends was influential prior to self-harm, that is, friends *"turning against"* them (P18, P23). The implication was that conflict challenged how these young people felt about themselves; being blamed for something, under pressure or not good enough. Participants linked these feelings with coping strategies, including self-harm.

8.4.2.3. Stressful life events and school pressures

Family trauma, change and breakdown were depicted as highly stressful. Death of a family member or friend was described as traumatic for both the young person and others in their family (P17, P22, P26). Parental physical or psychological illness, was repeatedly cited as both distressing and burdening the participants (P19, P22, P26). Having many duties at home was noted as a stressor, particularly responsibility for younger siblings (P17, P19, P25). This was also mentioned as a reason to feel pressure to conceal self-harm.

> *"... after a death in my family, my mum got ... my parent had got ill, she had depression so she went in a trauma, so like she just stays silent, she has negative thoughts how she's going to ... it's something she's going to ... she's not going to live any more and stuff like that, so because of that we had a lot of problems in the house."*
> *(P22, female, 15, Asian Indian, line 37, had self-harmed more than once)*

Schoolwork and pressure to perform at school was noted as a challenge by the majority of the participants. Three participants directly referred to schoolwork when discussing self-harm (P14, P23, P25). Not meeting expectations was intertwined with their description of the role that schoolwork played in their self-harm (P23, P25).

> *"Like, if I've been really stressed at school and I'm falling behind with schoolwork and ... but there's no-one like I could talk to about it, so I would either withdraw from everyone, or cut myself, or something like that." (P25, female, 15, Black African, line 269, had self-harmed more than once)*

8.4.2.4. Exposure to self-harm or suicidal behaviour

In addition to influencing attitudes to self-harm, exposure to self-harm or attempted suicide in others may function as a trigger. This was verbalised by one participant whose mother admitted an attempted overdose to a counsellor, speaking in front of her children. In that example, hearing about her mother's actions was both a trauma in itself, as well as making an overdose seem an acceptable thing to do.

> *"I don't think it's good at all, but I think because it's just there and you hear about it, and hear about it, people think if they're doing it, what's wrong with me doing it?" (P19, female, 15, Black British, line 332, had self-harmed once)*

Peer self-harm was discussed more frequently. Peer exposure normalised the self-harm, and lifted inhibitions surrounding it (P18, P21, P23, P26). No participants spoke of being peer pressured into self-harming.

> *"You don't start because of friends. You start, it's ... when friends do it, you start ... it's like it becomes an option, it becomes another option… Sort of like listen to music or reading, it becomes another option. It's something you just try out." (P21, female, 15, White & Oriental Asian, lines 201-203, had self-harmed more than once)*

> *"Well, when I was doing it, I felt OK, it doesn't matter; other people have tried it, so I might as well, but afterwards it hurts." (P18, female, 15, Asian Bangladeshi, line 160, had self-harmed once)*

Discussion of self-harm between friends had mixed effects on the participants. Some simply knew that others were self-harming. Others described feeling more accepting

towards themselves and their self-harm, knowing that others also did it (P18, P25, P26). A third group mentioned knowing that others talked about self-harm with approval, even encouraging each other, which they regarded as distasteful (P4, P21, P23, P26). Some participants spoke of strong disapproval by their friends (P5, P25). Although these attitudes influenced disclosure of self-harm more than the behaviour itself, it is worthy to note that the need to hide harm from others was evident alongside some peer influences which encouraged self-harm.

8.4.3. Are there specific links between precipitants & self-harm?

Given the range of precipitating factors, the questions remain – are there any direct associations between these background and triggering factors and self-harm? And are there any indications why these people self-harmed, rather than responding in some other way?

Participants talked of having 'no reason' to self-harm, despite outlining stressful issues they were facing and emotions they found difficult to express, highlighting no awareness of a direct link between precipitants and their behaviour. An accumulation of stressors and situational factors reinforced the complexity identifying what may lead some people but not others to self-harm. Some participants who had not self-harmed postulated that as they have reasons for their actions, people who self-harm are likely to have reasons as well (P1, P2, P6, P8), however some also claimed to see no reason to actually hurt yourself (P1, P8).

One link between precipitating factors and self-harm was the desire for pain, blood or physical rather than emotional pain. This was only the evident in people who talked of repeatedly hurting themselves. Whether it was a learned response to deal with distress (P25), or a need to hurt something (P30), the desire for pain played a key role for some participants. The need for release was also mentioned, however, self-harm does not obviously equate to release, whereas it does equate to causing pain or injury. One participant would hurt himself every time his wounds healed, and thus his previous harming was a form of trigger. He simply wanted to keep on doing it (P29).

The variation in accounts illustrates the inconsistency in thresholds for coping, and it is difficult to draw clear conclusions other than about the variations in triggers. For example, bullying was reported by people who had and had not self-harmed, indicating resilience in some people and not others. Nonetheless, there were some findings from this study which linked distress with self-harm for some young people.

Some participants were emphatic about not wanting to take out their feelings on anyone else. This may have been to protect others who were vulnerable in some way, such as being young or being unwell. Alternatively, they may have wished to keep their feelings separate from conflict between other people, such as parents who were arguing. Having nobody to talk to and feeling isolated were cited as triggers. That is, being unable to talk about feelings could potentially give someone the impetus to self-harm.

The lack of emotional availability of parents was repeatedly mentioned as a precipitant, being a key component of perceived isolation. The power of family relations and the emotional dependence on families during adolescence was reflected in the intensity of emotions leading to self-harm. The reported disappointment, perceived distance or rejection from family reinforced a lack of self worth, incited a sense of disinhibition, and lack of care about their actions.

> *" if you had someone there ... it wouldn't come to your mind to do those things, but it's at a time when you have ... when kids have no-one at all that you would do the craziest things, and not care at all how it hurts you" (P11, female, 15, Black African & Asian, line 262-4, had self-harmed once)*

This sense of isolation is reminiscent of the perception of having limited options to deal with a stressful situation. There was reference to not knowing what else to do, or how else to express their feelings given the external restrictions on their behaviour.

> *"I think well not so much culture, I think it's the way you're brought up.* (EK: Uh huh) *It's, like, if you can go out, like, you'll go out and do the more worser things, like, go to pick up drugs, and stuff like that. But whereas if you're at home, you'll just ... you just full of worriness and sorrow and you'll probably cry yourself to sleep and, like self harm and stuff like that. (P17, female, 15, Asian Bangladeshi, lines 508-510, had self-harmed once)*

Although no participants directly talked about cultural issues leading to their self-harm, culture was infused in a number of the stressors described. Culture may have influenced social and family norms, expectations on young people and also how they expressed themselves. Two female participants clearly associated restrictions of family and cultural values with the pressure that led to their self-harm, as they did not have scope to influence the limitations imposed on them (P14, P20).

> *"My parents are really strict with stuff like going out like ... that's why I feel a bit ... my parents are really like doing stuff from back home, and they're doing all the stuff culturally and it's just really weird, because I want to go out with my friends, but they won't let me go out with my friends, and the more they do that, the more I'm like pushed away from my family." (P14, female, 15, Asian Pakistani, line 122, had self-harmed once)*

> *"if you've got Pakistani parents, then ... I don't know, it's just the way they are, the way the culture is, like, they would want you to do good and stuff. It's not like if you had British parents, they wouldn't want you to do good, but ...* (EK: Yeah…?) *It's just like a bit more on the Pakistani side of it." (P29, male, 15, Asian Pakistani, line 92-94, had self-harmed more than once)*

Cultural norms were not consistently depicted as putting pressure on these young people. It was noted that each family would be different, illustrating variation within cultural groups (P5, P11, P21) and emphasising how each person had been brought up.

It is also worth noting that culture has a wider definition, and may relate to more than just one's ethnic group or family background. One participant who had not self-harmed referred to 'Emo culture'. Although this was not a dominant view in this sample, it highlights a perception that music culture may influence the acceptability and desirability of self-harm.

> *"there's that phase about Emos and how they slit their wrists, and stuff"*
> *(P4, female, 15, White & Black African, line 198, had never self-harmed)*

Participants who had not self-harmed suggested problems which may be triggers. Their suggestions reflected the issues raised by those who had self-harmed, including family, school, or self-esteem problems, receiving attention, or the desire to express stress or anger. This illustrates that although not all participants had self-harmed, there was some understanding about it across the sample.

Attempting to clarify links between stressors and self-harm highlights the complexity of personal, social and cultural influences on young people growing up in East London. This implies that it is not the complexity which leads to self-harm, as all of these young people faced many challenges during their adolescence, and not all of them self-harmed. This also shows that self-harm in response to these challenges is not necessarily associated with any ethnic group, cultural conflict or problem.

8.5. Personal experience of self-harming

This section will provide a descriptive account, summarising experiences of those who had self-harmed. It will present details from accounts about the actual experience of self-harming and the aftermath of self-harm.

Talking about personal experience of self-harm was a delicate issue for the majority of participants. Only one participant refused to discuss the issue (P24). Others spoke about self-harming briefly, not wishing to dwell upon their experiences (P12, P15, P16, P17, P19, P27). The experiences outlined in the following sections are therefore limited to interview participants who had self-harmed and were also comfortable talking about it.

The sample included people with varying experience of self-harm. When describing their experiences, some participants recounted a 'bout' of self-harm during which they had hurt themselves a number of times, yet viewed it as one episode of "self-harm" at a time of crisis. Thus some young people conceptualised self-harm not as physically acting to hurt themselves, but as a period of time during which they did so (P20, P22, P27).

8.5.1.1. Intentions when self-harming; deciding or "just doing it"

Participants did not give clear accounts of their intentions when self-harming. When recounting their experiences, participants described triggers, and then their self-harm, without demonstrating clear connections or knowledge of their intentions. Views on their intentions may have changed over time, or may have been tailored to their audience.

Participants were hesitant when discussing suicidal ideation, as outlined earlier. Two participants described starting to attempt suicide, and stopping or being stopped in the process (P11, P19). Reference to feeling suicidal was not related to the lethality of the

method used, for example, one participant who was *"feeling like life isn't worth living"* (P13, line 130) self-harmed by pinching and punching herself.

Other participants were quite clear that they were not thinking about suicide, and *"just did it"*. They described that they were feeling so much, that they did not think about it while they were self-harming. There is also the possibility that their feelings were too painful to think about, to admit or put into words. Alternatively, some were aware of wanting to distract themselves from how they felt (P23), or looking for a release (P20, P21, P25, P26).

> *"when you do it, you don't really think about it. You just sort of do it to ... I don't know how to explain" (P21, female, 15, White & Oriental Asian, line 177, had self-harmed more than once)*

Some of the people who repeatedly self-harmed were aware that it made them feel better. Despite talking of "just doing it" and realising what they had done afterwards, they were also motivated by the feelings they knew it would bring (P25, P29).

8.5.1.2. Details of the self-inflicted harm

As noted in the section 8.3., a range of self injurious behaviours were reported by these young people. Cutting and scratching were the most commonly reported self-injury, mentioned by six participants who had self-harmed more than once, and two who had self-harmed once. Although the details were not explained by many participants, implements mentioned included blades, scissors and knives. When bodily location was disclosed, this cutting and scratching tended to be on the arms, hands or wrists.

> *"And then I got a knife and cut myself with it. And then, erm, I forgot what happened after that." (P16, female, 15, Asian Bangladeshi, line 362-4, had self-harmed once)*

Overdosing was reported by two participants who had self-harmed repeatedly and three who had self-harmed once. The overdoses tended to be on their mum's pills or paracetamol, which were easily accessible at home. Other forms of self-harm mentioned included not eating and withdrawing from others (P25), knowingly taking risks without caring (P14), and digging fingernails into hands (P22). Another described putting half her body outside a window, threatening to jump (P11). In terms of self-battery, pinching and punching were mentioned by three participants (P13, P22, P26). Five participants had punched walls, leading to bruises and sore hands (P20, P21, P26, P28, P30). One

participant described punching a wall hard enough to fracture her hand (P26). No participants detailed any form of ritual in their self-harm.

8.5.1.3. Feelings while self-harming

Participants grappled with trying to explain how they felt while self-harming, as opposed to how they felt before or afterwards. That is, participants described that knowing they would feel better as their main feeling at the time, focusing on how it would make them feel afterwards, rather than how it actually felt then (P22, P25, P26).

> *"It feels kind of weird, you'd have to like do it to know how it feels, kind of. Can't really explain it." (P29, male, 15, Asian Pakistani, line 164, had self-harmed more than once)*

As noted in the discussion of background factors, feeling angry while self-harming was frequently reported (P11, P14, P15, P20, P21, P25, P27, P30), as was feeling low or down (P11, P13, P19, P23, P25). Similarly, having no other way to express themselves and not knowing what else to do was described as part of actually self-harming (P11, P13).

For some, feeling pain or seeing blood was important in describing how it felt at the time. This was reported by girls who had self-harmed more than once. They knew the physical injury or visual impact of blood would displace their emotional pain or elicit the relief they were seeking (P23, P25, P26). The boys who repeatedly self-harmed reported less emotional attachment to the pain, simply stating that they knew it would hurt after doing it (P29, P30), and felt calm at the time (P30).

> *"Seeing the blood pour out, it was just like, yeah, my anger's going away." (P20, female, 15, White Turkish, line 358, had self-harmed more than once)*

> *"And I think when you're at the moment when you're going self-harm yourself, the pain doesn't even seem painful to you." (P11, female, 15, Black African & Asian, line 264, had self-harmed once)*

8.5.1.4. Feelings after self-harm and about the physical evidence of self-harm

Participants who talked through their experiences described a sense of release immediately after self-harm. Seven participants mentioned this feeling and some viewed it as making them feel *"strong"*, *"good"* or *"better"* (P16, P21, P22, P25, P27, P29, P30). Two participants described going to sleep after they had hurt themselves (P16, P21). Some noted that the relief was only temporary, as their problems would not have changed. Others explained that the visual aftermath of self-harm made them feel better.

> *"It's like I had to cut myself, because, as I said, when I do cut myself I feel a sense of release, like away from all the other problems for a few minutes"*
> *(P25, female, 15, Asian Bangladeshi, line 147, had self-harmed more than once)*

> *"And then when I see that mark, I think, I've hurt myself, so I feel better."*
> *(P22, female, 15, Asian Indian, line 275, had self-harmed more than once)*

Six participants described feeling the pain, or hurting in some way after harming themselves (P11, P13, P18, P22, P25, P28). Some recalled not feeling pain at the time, only becoming aware of it afterwards (P11, P18, P28). This pain may have been transitory, in the case of those who were pinching themselves, or more long-lasting in the case of more severe cutting or overdoses.

> *"Because it doesn't hurt at the time, but afterwards, it does hurt. Because when you do it, you're angry and you're upset, and you don't ... and then you think, oh, it's going to make you feel better, but then it doesn't." (P18, female, 15, Asian Bangladeshi, line 158, had self-harmed once)*

Feeling the pain from self-harm was accompanied by other realisations. Three participants explained that it was not until afterwards that they understood how their actions may have killed them (P14, P16, P17). Others expressed regret after harming themselves. Regret was associated with the notion that their self-harm would hurt only them, and not change the problems they were facing. Two participants clearly stated that they had no reason to hurt themselves and that it had not helped, however, it was unclear from their accounts how soon after their self-harm that they had come to this conclusion (P15, P27).

> *"But then five minutes later, after I've done it, I think I shouldn't do it, because like then it's hurting me. But nothing ... nothing happens to that other person who's shouted, it hurts me at the end of the day." (P22, female, 15, Asian Indian, line 293, had self-harmed more than once)*

> *"I regretted it… Erm. It was just like ... it was like making myself ugly for no reason, just making my arm look all scarred and everything, no reason, it was just ... I just wanted it to be over, basically, what was going on, just to end." (P27, female, 15, Black British, line 240-242, had self-harmed more than once)*

Four girls talked of feeling upset or depressed after self-harming (P13, P19, P23, P25). This distress may have related to the comprehension of potential outcomes of self-harm. For example, P19 did not continue with the overdose she had started as it upset her to imagine her younger sister finding her if she did not wake up. Alternatively the sense of guilt might have been a form of self-reproach for self-harming again, rather than dealing with the situation in some other way, as recounted by P25.

A sense of confusion was intermingled with feelings immediately following self-harm. When describing their initial episode of self-harm, some participants explained that they were confused by their actions, and could not understand why they had done it (P16, P19). Five participants described no particular feelings about their self-harm or the scars it had left (P12, P21, P28, P29, P30). For those who had self-harmed a few years earlier, memories of the events and their feelings may have changed in the intervening time.

The relationship with physical marks or scars varied between participants. Some participants made no mention of their scars. Others made a reference to their efforts to keep any evidence of self-harm hidden (P24, P25), disliking their scars (P27). One participant talked of her self-harm in terms of *"getting scarred"*, and how she had used sharp objects to give herself scars, rather than discussion of the cutting which would have caused the scars (P23). This participant kept her scars hidden when she was self-harming but made a point of rolling up her sleeves to show them during the interview.

> *"it's one of those things when you feel ... when you feel really, really low - the lowest - that you think that the pain will go. And then back then, I didn't learn about the fact that the scars helped me remember. And now I know that and now I'm more cautious of harming myself again." (P23, female, 15, Asian Sri Lankan Tamil, line 458, had self-harmed more than once)*

The three boys who had self-harmed were at ease with their scars. For the boys who talked of punching walls, bruises were seen in a fairly positive light, and there was no qualitative difference between scars they had given themselves, those from fighting or any other cause (P28, P30). For the participant who discussed using his self-harm to elicit a response from others, the public display of his wounds had played a major part in his self-harm and he had no compunction about showing his scars while wearing his school uniform (P29). There was one girl who spoke about not hiding her scars anymore. She also commented that when her friends had been self-harming, they maintained an awareness of their image and wanted to look good, and thus showed elements of prioritising self care while also self-harming (P21).

> *"I used to ... sometimes I wore gloves and stuff, I've got mates who wear gloves. But you get to the stage where it's like, you know what? Who cares! I'm not gong to hide a part of myself. Why should I?"* (EK: Uh-huh) *"It's part of who I am, it's part of what I once did. So there's just no point." (P21, female, 15, White and Oriental Asian, lines 275-277, had self-harmed more than once)*

8.5.1.5. Cessation of self-harm

Attitudes to cessation of self-harm primarily related to the participants' own experiences. One participant who had never self-harmed spoke confidently about a friend who had stopped harming as she had told her was not a good thing to do. She implied that stopping self-harm was a straightforward process, and that her friend would have done as she said (P5). Although some people who had self-harmed also put it that simply, most implied that stopping harming was more complex than it may initially seem. For those who continued to self-harm, there was a mix of people who had a desire to stop but were finding it difficult (P22, P25), and some who did not wish to stop as they did not see it as problematic (P26, P28, P30).

Those who no longer self-harmed described a conscious decision to stop. Reasons for not self-harming included it being against their religion (P26), no longer seeing the point in doing it (P19, P21), knowing that it would only hurt them (P22), appreciating that it did not help or was not the best way of dealing with things (P21, P25, P26, P27). Others did not wish to do something which may actually kill them, expressing a fear of dying (P12, P14, P16, P17, P20). For some, cessation of self-harm was linked with the resolution of the problems which had inspired it (P15, P27). Reflection on previous attempts included an awareness of how they had not cared what happened at the time, and how they no longer felt that sense of disinhibition (P14, P17, P20).

Family members played an influential role in cessation of self-harm. For example, one participant described being physically stopped and questioned by her sister as she cut herself (P11). Participants reflected that their stopping was influenced by not wanting their families to find out what they had done (P23, P26) as it might upset them (P12, P19), or as it might influence their family's reputation (P12, P14).

> *"And like sometimes I felt like really hurting myself or something, and I thought, oh, no, because it might reflect on my family or whatever, and then they would be upset and think it was about them or something." (P12, female, 15, White Irish & Welsh, line 212, had self-harmed once)*

There were accounts of having the motivation to stop, but finding it very challenging. For example, P25 described her self-harm as like an addiction she felt too weak to overcome, despite the motivation of her aspirations for the future and desire to set a good example for her younger siblings.

The outcomes and response to self-harm may have also influenced some young people, giving them the motivation to try to stop. Three participants mentioned still thinking about self-harm and making an effort to stop themselves. One mentioned wishing to avoid the aftermath of his previous harm (P29), another talked of convincing herself to just leave it and forget it (P12), while the third focused on thinking of other things to do instead (P26). P21 explained that she simply stopped at some point, yet conceded that ceasing to self-harm may not be as straightforward for others (P21).

8.6. Disclosure of self-harm, informal help-seeking & social context social

A central aim of this study was to explore disclosure of self-harm. In order to provide some context, participants' comments about their social relations will be briefly described. Outcomes of self-harm may involve the person self-harming and also the people around that individual. This section will outline participants' comments about social networks and social support input from others. The next section (8.6.1.) will address their attitudes to social support and talking to others about themselves and personal issues in general. These two sections will include comments from both those who had and had not self-harmed. These provide the background for the section 8.6.2., which explores the disclosure of self-harm, informal help-seeking about self-harm and the associated challenges.

Social context

When asked about close people in their lives and how they spent their free time, all participants referred to their family and friends. Most participants felt their family members were the most important people to them, and talked of enjoying spending time with friends. All participants talked about having a social network, with different people playing different roles within their lives.

> *"I just like to go out with my friends and have a laugh."*
> *(P18, female, 15, Asian Bangladeshi, line 8, had self-harmed once)*

A range of social contexts and relationships were described. Social networks included structured groups such as youth clubs (P6, P19, P27) or playing sports (P9, P13, P14, P28). Physical proximity was noted in descriptions of social networks, for example, talking

with neighbours, having friends from school or living in the same area (P14, P15, P17, P20, P25, P28). Boyfriends or girlfriends were mentioned by only a few participants (P12, P14, P27).

The need to be wary of who to trust was highlighted by participants, irrespective of whether or not they had self-harmed. Numerous participants reported an awareness of changing their behaviour and conversation depending on the circumstances (P10, P14, P23, P25, P26, P27).

> *"But if I can see someone's being fake towards me, then I will just be as fake with them." (P27, female, 15, Black British, line 80, had self-harmed more than once).*

Participants spoke about knowingly keeping a distance between themselves and others. Twenty three participants mentioned time alone as a response to distress. However, a sense of isolation was only mentioned by participants who had self-harmed. Feeling isolated may have been in the past (P20), very recent (P24) or ongoing (P14, P22, P25, P29). The sense of isolation may have related to their family (P14, P29), their peer group (P24, P25), or both (P22).

Family conflict or separation was mentioned by young people irrespective of self-harm status or ethnic group (P3, P7, P11, P19, P21, P25, P26, P27). These issues did not differentiate people who had and had not self-harmed, however, they may be relevant to self-harm and help-seeking for some young people.

Online communication, such as using MSN was mentioned by participants with and without experience of self-harm (P1, P12, P14, P16, P21, P23, P29). Web-based chatting enabled communication with people they were unable to interact with directly, due to distance (P29) or family rules (P14, P15, P17, P20).

Participants referred to the wider community in general terms, relating to different ethnic or cultural groups within their local community, having friends from different backgrounds (P3, P4, P10, P14, P19, P21, P24, P25) or the need to uphold the family reputation (P14, P15, P17, P20). References to culture included comments about limitations on socialising (P14, P17, P20).

> *"And they have a fit on me, saying, "Oh, my god, he's a boy. He's the same age as you. You can't be ... you can't be like talking to each other." That's another thing got to do with*

culture wise. You can't be mixing with boys." (P14, female, 15, Asian Pakistani, line 248, had self-harmed once).

Although relationships with family were mentioned by all participants, they received more criticism from young people who had self-harmed. Some participants expressed disappointment in their family relationships (P11, P19). Others were critical of the family values to which they felt expected to conform (P14, P15, P20) or the burden of family responsibilities (P14, P15, P17, P25). When asked about culture relating to their family, some felt they would have trouble talking with their parents about the issues they had with culture, as their parents would not understand (P14, P15, P20). Others said their communication with family related to who they were as individuals, rather than their culture or where they had grown up (P3, P5, P21, P23).

8.6.1. General help-seeking and attitude to talking about problems

This section outlines comments about informal support and talking to others when upset or angry, irrespective of whether the young person had self-harmed. Distress itself may not be a sufficient precursor of seeking formal or informal help. Other factors are involved, such as the perceived need for support, belief that help may be available, and the perceived usefulness of that help. Nineteen participants mentioned hiding or keeping feelings to themselves to some extent when distressed (P2, P3, P4, P5, P7, P8, P13, P14, P15, P17, P18, P19, P20, P21, P22, P23, P24, P25, P28).

The majority of participants who had not self-harmed reported knowing that support was there, and they could talk to someone if they needed (P1, P2, P3, P5, P6, P7, P8, P10). This reliance on available support was mentioned by fewer participants who had self-harmed (P11, P12, P13, P23, P26, P27, P30). Some participants, particularly those who had self-harmed, described feeling more comfortable listening to others about their problems compared with talking about their own (P3, P11, P14, P19, P21, P24, P27). Others emphasised the importance of reciprocity in support; being there for other people who were there for them (P2, P11, P12, P14, P19, P21).

Participants varied when discussing talking to others about how they were feeling. Some participants felt comfortable talking to others as it made them feel better (P1, P6, P11, P13, P20, P23, P26, P30). Participants who had difficulty talking about themselves, or were not comfortable showing how they felt, had negative views on disclosing problems to

others (P16, P19, P23, P24, P25, P28). This was reported only by participants who had self-harmed. Some young people simply did not often talk about their feelings (P2, P7, P9, P10, P18, P24). Participants were guarded about how much they disclosed, and to whom (P3, P4, P18, P21, P25).

> *"But telling people something is letting sort of part of yourself go, if you know what I mean. Once you've told it, that's it, you can't take it back. You've told somebody something and they can do whatever they like with it." (P21, female, 15, White & Oriental Asian, line 127, had self-harmed more than once)*

Mixed experiences were reported when having sought informal support (P11, P20, P21, P23, P24). Many participants found it difficult to generalise, as their attitude to seeking informal support would depend on both the situation and who might be available for them to approach (P2, P3, P5, P6, P12, P15, P19, P21). Participants explained that it may be appropriate to talk to different people in their lives at different times. Reasons given for not talking to others about feelings included not trusting them (P17, P22), concern about negative responses (P2, P17, P22), and regret about having talked about their concerns in the past (P20, P24). Attitudes to help-seeking also reportedly changed over time.

Friends and family were the main sources of support, with eighteen participants saying they would talk to a close friend if distressed or angry (P1, P3, P5, P6, P8, P9, P10, P11, P12, P14, P18, P20, P23, P24, P25, P26, P27, P30). Family members approached for support included their mum (P1, P4, P5, P13, P16, P23, P26, P27, P30), dad (P4, P17, P30), siblings (P3, P11), cousins (P11, P14) aunts or uncles (P11, P13). Although support from teachers or school staff was mentioned (P4, P14, P20, P23, P30), there was some hesitation about relying on teachers for emotional support (P18, P20). A sense of wariness about potential confidantes was mentioned by participants, irrespective of self-harm status. The anticipated response from others was central to their attitudes about seeking informal support when distressed about personal issues.

> *"they either think you're being selfish ... like, not selfish but you're being, like, self centred, you're doing it for pity, like, you're attention seeking or you're bloody nargh!"*
> *(P17, female, 15, Asian Bangladeshi, line 504, had self-harmed once)*

Seeking support related to the expectations held by the young person, and what they hoped for when approaching someone else. Different intentions were reported, including looking to be cheered up (P12), calmed down (P6, P12, P16), comforted (P12, P19), have their worries acknowledged (P17, P20), to seek advice (P5, P13, P20, P27), to be

accepted (P3), or helped to find the funny side of the issue (P25). Others simply wanted someone to listen (P11, P29). It was acknowledged that talking to friends was unlikely to solve family problems (P14, P17, P19, P27).

Availability and approachability were salient factors in seeking social support. For example, if a young person felt they would have to talk in front of their family, it may inhibit them from calling somebody to discuss how they were feeling (P15). Availability included potential sources of support being interested in what the young person had to say, rather than downplaying their concerns (P3, P17, P20, P26). Characteristics which these participants felt would make someone easy to talk to included believing that they were trustworthy and would keep the conversation confidential (P1, P12, P13, P19, P21, P22, P23). There was a desire that the young person would know the potential confidante well, (P21, P23).

> *"but close friends I might like talk to them if I feel stressed, like what happened. And they will like ... they'll understand, they'll agree, and they might feel like that happened to them.* (EK: Uh-huh). *So, you connect with each other by saying that they know how you feel." (P8, male, 15, Asian Bangladeshi, line 236- 238, had never self-harmed)*

Similarities between participants and potential listeners were important. Examples of similarities included age (P18, P23), having had similar experiences, (P8, P11, P29) or a shared cultural background (P15). In contrast, a few participants described feeling more comfortable seeking differences in their confidantes, looking for other opinions (P5, P11), or not having to include their cultural values into the discussion (P14). Confidantes were described as being able to listen attentively, to be understanding (P6, P8, P18, P27, P29), readily available (P12, P13, P29), friendly and making them feel comfortable (P5, P6, P9, P19, P23, P25). This will be discussed further in sections 8.6.2 and 8.6.3. addressing informal and formal help-seeking for self-harm.

8.6.2. Disclosure of self-harm and informal help-seeking

Having introduced social networks and participants' views on communicating about personal issues in general, the following section addresses disclosure of self-harm. Difficulty in expression may be a contributing factor to self-harm, and therefore discussing one's self-harm and the associated problems might be particularly challenging. Talking about self-harm may involve discussion of precipitating factors in addition to the harming itself. Disclosure may be initiated by the person who had self-harmed, or discovered if

marks or scars from self-harm were seen by others. The desire to keep self-harm private was expressed frequently (P17, P21, P23, P24, P25).

The sample included participants who did not see the need to talk about self-harm. If participants believed they had put their harm behind them, they did not relate their self-harm to their current situation, and expressed no desire to think about or discuss it (P19, P20, P27). Some did not view their actions as something they would need to talk about (P15, P18, P21, P26, P28, P30). Self-harm was not deemed problematic if the person was in control of it (P21, P26, P27).

> *"I didn't tell anyone about the harming, erm ... yeah, I don't know. I just didn't tell anybody." (P18, female, 15, Asian Bangladeshi, line 180, had self-harmed once)*

> *"It's generally something that's kept to yourself" (P21, female, 15, White & Asian Oriental, line 269, had self-harmed more than once)*

Numerous participants reported difficulty in verbalising feelings and experiences pertaining to self-harm. Those who were more comfortable with seeking support in general seemed to be more at ease with the idea of talking about self-harm. However, this was not consistent, as some participants reported speaking with friends about other problems, while being uncomfortable talking about self-harm (P14, P17, P21, P25).

> *"I was pretty stupidly going to ... oh, I feel like a bit ... like an idiot saying this, but, erm, self-harm." (P14, female, 15, Asian Pakistani, line 146, had self-harmed once)*

The reluctance to talk about self-harm often centred on the fear of a negative response from others, or the desire to maintain privacy. Some claimed that they would like to talk about it but did not know how (P13, P24, P25, P29). Others were not certain that they wished to speak about it, as it was not easy to talk about (P15, P17, P19, P21). A sense of shame was expressed by some participants who had self-harmed and never disclosed it (P13, P23, P25).

> *"like my friends would think ... they'd think I'm pathetic or something like that." … (P25, female, 15, Black African, line 165, had self-harmed more than once)*

> *"But it's the fear of talking to someone and then getting it thrown back in my face." (P25, female, 15, Black African, line 207, had self-harmed more than once)*

Stigma and misunderstandings about self-harm may complicate communications about it. Having a social network may also function as a preventative factor for disclosure of self-

harm (P17, P24, P25). For example, one participant explained that her friends thought self-harming was *"stupid"* (P25, line 357) or *"attention-seeking"* (P25, line 178), and that those disparaging attitudes convinced her to keep her self-harm hidden. Another participant attributed recent distressing social isolation to her attempt to discuss her harming with a close friend (P24). Some participants chose to keep their self-harm to themselves despite having a varied social network, including people they trusted (P21, P23).

As participants often found their own self-harm difficult to understand or comprehend, they felt that others would find it hard to understand as well. Akin to discussion of general support, participants knew some people who could be confided in, and some who could not. Different parts of their social networks served different roles in their lives, for example, participants reported telling friends more frequently than telling parents (P13, P21, P23).

> *"It was only important to me that my parents didn't know, because they would have gone mental." (P23, female, 15, Asian Sri Lankan Tamil, line 450, had self-harmed more than once)*

When discussing who they would talk to about their self-harm, participants outlined characteristics reminiscent of those described for general support seeking. Trust was essential. Other key features included listening, being understanding, and not shying away from what was being said (P12, P16, P21, P25). Repeat self-harmers explained that a particularly desirable feature was that potential listeners had also self-harmed, as they would be more likely to know how it felt (P25, P26, P29).

> (EK: What would you be looking for from them?) *"For them to understand that I'm just not some girl who doesn't know how to deal with her feelings properly, but ... yeah, understanding, like where I'm coming from sort of thing." (P25, female, 15, Black African, lines 176-177, had self-harmed more than once)*

Participants expressed difficulty in knowing how to respond to self-harm in others, irrespective of their own experience of self-harming. Of those who had previously self-harmed, some did not relate to self-harm in others, viewing their own experience as qualitatively different from their friends. Others drew on their experience to discourage self-harm (P12, P15, P17, P18). Only two people who had repeatedly self-harmed described that finding out about others' harm reinforced and normalised their own (P25, P26).

> *"I was shocked. I was like ... because I didn't know she self-harmed. And it's like she doesn't ... she doesn't do it, like, oh, like how I did it, just to scratch; she actually like does it a lot and I was like ... OK. I didn't really know what to say to her."*
> *(P18, female, 15, Asian Bangladeshi, line 344, had self-harmed once).*

Participants who had not self-harmed showed little empathy or acceptance of self-harm. One boy who had not self-harmed commented that if he were to hear about someone self-harming, *"I'd just let them, you know, I wouldn't get involved."* (P9, male, 16, Black African, line 240). Comments from people who had not self-harmed gave credence to the concerns about disclosure expressed by those who had.

> *"I just think she's attention seeking, because if you ... if someone really had to self-harm and they felt that low, they wouldn't be expressing it to everyone else, because they'd feel so bad within themselves. They wouldn't like be like putting on a show like, "Oh, I have to do this, because I feel so bad." You'd do it and you'd keep it private, because like she goes around the school like this, and she's all like ... and she puts her sleeves ... pulls her sleeves up" (P4, female, 15, White & Black African, line 196, had never self-harmed)*

A negative reaction to the physical outcomes of self-harm may also inhibit communication. This is a key difference between discussion of self-harm and other issues. Female participants with physical evidence of their self-harm talked of making efforts to keep it concealed in most situations (P21, P23, P25, P27). However, as noted previously, some people made use of physical injuries to communicate their distress.

The notion that self-harm could be used as communication to elicit a response from others was reported by people who had and had not self-harmed (P4, P20, P29). Only two participants in the study reportedly wanted others to see their self-harm. For example, a 15 year old Pakistani boy reported wanting others to see his injuries, letting them communicate for him. For that participant, knowing that his self-harm was seen and passed on to others was reassuring and ultimately helpful.

P29: I used to have quite strong thoughts in my mind about telling other people about it.

EK: Uh huh.

P29: Like, and ... (long pause)

EK: What would you have liked to have told them?

P29: Probably like ... the thoughts I used to have after like ... after cutting myself and before cutting myself, were, like, just-just show somebody, like.

EK: Do you remember why you wanted to show somebody?

P29: (long pause) Not really, no.

EK: Did anybody ever find out?

P29: Quite a few people. Mmn. Like it started off at the hospital, so the nurses saw it.

EK: Uh huh.

P29: And then it just spread through, like, doctors and then family.

EK: How was it for you when the nurses saw it?

P29: Well, I was ... a little bit more happy, because now I knew that like ... I don't know. Because when I knew that like they knew that what I was ... because like, I wasn't a good talker, like, back then, so ... that's why I knew that they would kind of help me in some way now, or something. (male, 15, Asian Pakistani, lines 174-186)

For some, their self-harm became public when other people saw evidence of it, and then told others, irrespective of the wishes of the individual involved (P27, P29). This experience removed the young person's control over who knew about their harm. For example, one 15 year old girl related that marks from her self-harm had been seen by peers at school, reported to teachers and then her family (P27).

"I was like, "How did you know?!" So much people, like, a lot! I was just amazed how they knew, because I don't ... because I didn't tell any of them."
(P27, female, 15, Black British, line 300, had self-harmed more than once).

For a few participants who had stopped harming, others finding out about their self-harm was a mixture of both positive and negative experiences. There was a reluctance to tell others (P19, P26, P27). Despite the initial distress of their harm being discovered, beneficial outcomes ensued; including increased attention to problems within their families, or the young people feeling more valued themselves (P19, P27, P29). For another three participants, disclosure of their self-harm led to increased support and understanding from friends, helping them through that difficult time (P12, P23, P26).

"Actually it did make me feel better, like, I knew that people did love me and it made me feel better that someone else knew. I didn't want them to know, but it made me feel better in a way" (P19, female, 15, Black British, line 318, had self-harmed once)

"There was a time that you wanted to like tell people and everything, but then at the end of the day, you thought that they were going to think you're a weirdo and everything. But now that I've told the majority of my closest friends, erm, they're like more understanding, and everything like that. So it makes you think, like, why didn't you tell them sooner; they could have helped you stop as well". (P26, female, 15, Black Somali, line 440, had self-harmed more than once)

8.6.3. Formal help-seeking, attitudes and suggestions

There was a sense of uncertainty about seeking formal or professional help for self-harm. There was no consistency relating to who might be approached. Nor were there firm ideas about what help provision might entail, beyond the expectation of a less passive response

than from informal support. For many participants, the notion of seeking formal help was an abstract idea, and they discussed the reasons why they may or may not seek help rather than their actual experiences. This section will outline comments about perceived availability, expectations and reasons why participants would be reluctant to seek help.

8.6.3.1. Who would young people approach for help?

Having established that friends and family were most likely to be approached for support, participants primarily spoke about potential help from school or, less frequently, services. Teachers, form tutors, mentors and support staff at schools were named as likely candidates to be told about self-harm (P2, P6, P11, P15, P23, P27, P29). Teachers were viewed by some as a potential referral point for other help, not expected to provide support themselves (P2, P27).

> *"I don't think the school can do very much, because they're just doing their job, basically." (P27, female, 15, Black British, line 280, had self-harmed more than once)*

A range of help sources outside of school were mentioned. Potential sources of help included counsellors (P6, P21), people from Connexions (P15), social services (P27) or the police (P2). However, some participants claimed that there really was nobody to talk to about self-harm (P13, P18). Help from doctors or nurses was only suggested by people who had not self-harmed, or those who had received medical assistance at the time of their harm (P2, P3, P17, P29). Reluctance to seek help also related to the belief that talking about self-harm may not be well received.

> *"I don't like people who ... purposefully like try and attention seeking and like who go to hospital and waste doctors' time when they could be helping someone else, like to save life." (P3, female, 15, White & Black African, line 150, had never self-harmed)*

8.6.3.2. What might prevent young people from seeking help?

Although teachers were mentioned as a potential source of help, there was scepticism about potential responses, which participants saw as justification for keeping their self-harm hidden at school. Teachers were seen as unable to be of assistance (P19, P24), and predicted to watch over people who self-harmed (P12). There was a perception that pupils would be treated differently if teachers knew about their self-harm (P3, P27). Teachers were assumed not be trustworthy as they were likely to tell other teachers and parents (P2, P12, P21, P27), or were known to live within the same community as the young

people (P17). There was little insight shown by participants about why there may be a need for teachers to break confidentiality.

> *"But then the word just got passed around. And then they were trying to ... it's like they were trying ... they didn't want to get me angry. It was like they were treating me like I had a disability, I didn't really like it; they wasn't treating me like they would normally treat me if they didn't know that I was harming myself." (P27, female, 15, Black British, line 302, had self-harmed more than once)*

Participants gave other reasons justifying why they would not seek help. Some did not think they would need help for their self-harm (P26, P28, P30), or that it may take time to find the concept of help acceptable (P17, P21). Concerns were also raised about connections between people in helping roles.

> *"with my doctor, I'm just worried because he knows my mum and in case he might tell my mum, or something like that. And plus, because I'm only sixteen, I don't think they're going to let me go into the doctor's surgery alone, so my mum's going to be there as well."* (EK: Uh-huh), *"So it's kind of hard to speak in front of my mum as well."*
> *(P15, female, 16, Asian Bangladeshi, lines 389-391, had self-harmed once)*

> *"I don't think they should contact any sort of outside help, unless the student wants it. Because if the student's getting it, but doesn't want it, it's not going to help."*
> *(P21, female, 15, White & Asian Oriental, line 315, had self-harmed more than once)*

8.6.3.3. Participant suggestions for providing help for young people who self-harm

When asked what people who self-harmed would be looking for if they sought formal help, participants outlined similar responses to those they would hope to receive from friends and family. These features included having someone to talk to, being respected, listened to and being reassured (P2, P15, P21, P29). Participants hoped that professionals would explore their situation and problems in addition to responding to the physical harm (P1, P12, P14, P18, P24, P27, P29). There were higher expectations of formal help, desiring to be given advice about alternatives to self-harm, how to work through personal problems or about how to express themselves in other ways (P12, P15, P29). Participants also expected to be given reasons to stop harming, rather than being told to stop without justification (P5, P26).

There was no consensus about sources of help, or knowledge of potential gatekeepers. There was substantial concern about whether approaching someone in a helping role would actually be beneficial. Reservations about seeking help reinforced the secretive nature of self-harm.

8.7. Participant feedback about the methodology

8.7.1. Comments about the screening questionnaire

Each participant's questionnaire was present during their interview. A number of participants commented on the survey during the course of their interview. Some felt that it gave them a chance to reflect on how they dealt with challenges and to consider different options (P21, P22, P23, P30). The survey was deemed *"OK"*, *"fine"* or *"a bit weird"* by those who chose to comment (P5, P4, P18, P30). Four participants stated that the questionnaire addressed problems and coping strategies relevant to teenagers (P15, P23, P26, P30). One participant commented that she did not usually have the confidence to talk about how she felt, and that the questionnaire had helped her "open out" to someone (P22). Two participants stated that the promise of confidentiality made it easier for some to answer questions honestly about themselves (P15, P22).

In contrast, others stated that they did not trust the confidentiality of the questionnaire (P3, P26). While completing the screening questionnaire, it was not uncommon for pupils to question whether teachers would see their answers, despite having received written and verbal information about confidentiality. Participants commented that the questionnaire was asking very personal questions (P8, P26). Items noted as the most sensitive referred to issues which were still pertinent in their lives, or had been salient to their period of self-harm. These included parental arguing (P11, P25, P27), parental drinking (P11, P25) and the possibility of living in care (P13).

> *"I just thought ... not to be rude or nothing, but I just thought someone is coming into the school to see if the girls have, like, got problems and issues and they just want to be a bit like nosy or whatever. And they're going to run and tell the school, and tell social services and stuff like that. So I was just thinking to myself, well, let me just tick all this random stuff." (P3, female, 15, White & Black African, line 60, had never self-harmed)*

The issue of truthful responses in the survey was discussed in the interviews. Two participants explained that they did not want friends or teachers to find out about some issues in the questionnaire and so they considered not answering honestly (P24, P26). Such comments were in agreement with the views about disclosure of personal issues explored within the interviews.

8.7.2. Impact of the interview

The assessment of how the participants felt before and after the interview used a visual analogue scale. The numeric values (1-100) assigned to this assessment have little absolute meaning, however they do provide a sense of how the interview was received.

Of those who had never self-harmed, four reported no change, five reported feeling better and one participant reported feeling slightly worse after the interview. Reasons given for improved mood included feeling happy to be given the chance to talk. The participant who felt worse afterwards gave no explanation for the change.

Of those who had self-harmed once, two reported feeling slightly worse (up to 5% worse) after the interview, and seven reported feeling better, with indications of a 10-40% increase in their mood. The reasons given for feeling better centred on the benefits of talking about emotions and having someone who wanted to listen. Those who felt worse said it was because they were reminded of a time when they had felt sad and not dealt with things well. One participant stated that although talking about things can make you feel better, it could be emotional to talk about issues which have affected your life (P11).

Of those who had self-harmed more than once, two reported no change, two reported feeling worse (ranging between 10-30%) and seven reported feeling better (improvement of 5-55%). Only one girl reported feeling substantially worse after the interview. This was the participant who had refused to talk about her self-harm, beyond stating that she had done it repeatedly. Telling a friend about her self-harm had made things difficult for her, so she did not wish to talk about it. That interview was very brief, followed by a substantial de-brief. For those who had repeatedly self-harmed, reasons for higher scores after the interview focused around feeling better to have talked about their lives and issues they sometimes found hard to talk about.

> *"You know, speaking to people, yeah, it does help."*
> *(P20, female, 15, White Turkish, line 422, had self-harmed more than once)*

8.8. Summary

This study aimed to explore self-harm within East London adolescents. The use of semi-structured interviews enabled participants' to provide insights about the topics raised in the interviews, about their individual experiences of self-harm. Self-harm was portrayed as a complex, multi-faceted behaviour.

There were varied perceptions of what self-harm actually involved, and how acceptable it was. The term "self-harm" was known to all of the girls and half of the boys, although some of the participants did not relate their own self-destructive behaviours to that term. Punching walls was deemed more acceptable than self-cutting. Those who had not self-harmed described a lack of understanding about self-destructive motivations and behaviours, and most held negative views about it.

Anger was the most commonly described emotional precipitant of self-harm, and the desire to keep their emotions and problems to themselves. Peer exposure was depicted as something which normalised the self-harm, rather than as a direct encouragement to do it. A sense of isolation, and particularly distance from or conflict with family was salient in accounts of self-harm; however, these issues were also evident to some extent in the participants who had not self-harmed. Self-harm sometimes related to suicidal ideation, however, this was mainly acknowledged with hindsight. Feelings reported at the time related to not knowing what else to do while feeling distressed or angry.

There was rarely one reason for self-harm, with an accumulation of challenging emotions, situations and events leading to the behaviour. For those who had self-harmed repeatedly, the sense of release from distressing emotions reinforced self-harming behaviour. For some this also included a desire for physical pain or to see their own blood. Self-harm was noted as a short-term release, which would not alter the stressors, but would provide temporary relief.

Attitudes to self-harm varied with time and input from others, implying that views on self-harm were changeable. Later consideration of self-harm led participants to reflect that it was not such a good idea as they had thought, that they were not the only person who had hurt themselves, that they may have been suicidal at the time, or that there were other options to consider when angry.

Whether a single episode, or a number of episodes over a period of time, harming behaviour was time-limited for some young people. Some participants described a period of self-harm in their past which they no longer identified with, implying that they had self-harmed once or more than once in response to a period of distress. For some the distress dissipated, whereas others were given clear motivations to stop harming. Cessation was motivated by problems coming to an end, concern about their family, religious reasons, finding self-harm painful and not wishing to do things which may kill them. Those who repeatedly hurt themselves talked of consciously deciding to stop harming, or at least attempting to stop. This contrasts with accounts of starting to self-harm which were described as just having happened.

When discussing coping with stress more generally, participants described keeping their problems to themselves and being careful whom to trust. Participants, irrespective of self-harm status, mentioned a sense of wariness about potential confidantes. These general comments were reflected in discussion of disclosure of self-harm and the predominant desire to keep it hidden. When choosing a confidante, participants were most likely to tell a close friend about any problem, not only about self-harm. After friends and family, young people mentioned teachers and school support staff as potential confidantes. However, participants questioned whether they would trust teachers, without showing insight into why there may be a need for school staff to break confidentiality. Having a social network and available support did not necessarily encourage talking about self-harm. That is, participants explained being comfortable to talk about other problems alongside a reluctance to talk about self-harm. If their self-injurious behaviour was not viewed as problematic, participants felt no need to discuss their actions.

Some people who had self-harmed had difficulty talking about themselves and were not comfortable to show how they were feeling. This was not expressed by any of the participants who had never self-harmed. Those who were less comfortable talking in general also expressed difficulty with the notion of talking about self-harm. However, there were participants who openly showed others their self-harm, using the injuries to communicate distress for them.

The reluctance to talk about self-harm often centred on the fear of a negative response from others. Disclosing self-harm functioned to upset others, who reacted to both the physical aspect of the harm as well as the psychological distress it may represent. Some

young people whose self-harm had been discovered by others criticised a lack of sensitivity in the response they received. With hindsight, the initial difficulties of private harm becoming public were viewed more positively, particularly if knowledge about their self-harm had led to increased support or changes to the situation causing their distress.

Within this exploration of self-harm, there was limited evidence in participants' accounts for an influence of ethnicity or culture on self-harm. Participants did not portray that their own or any other culture condoned self-harm, however, there were references to the role of the community, and maintaining the family reputation. Culture plays a role in identifying groups, which may lead to conflict in some cases, or perceived differences between normal behaviour for different groups. Restrictions on behaviour relating to cultural and family values were primarily spoken about by girls. Although culture was not portrayed as a direct precursor of self-harm, it functioned to exacerbate other stressors for some young people; influencing expectations on them, inflaming difficult circumstances within their family, restrictions on behaviour, socialising and possible ways of seeking help or support.

9. Discussion

9.1. Introduction

This chapter will bring the different aspects of the thesis together illustrating how this work has addressed the aims in Chapter 1. Section 9.2. will present a summary of the main findings of the two studies conducted for this thesis. This will be integrated with a commentary on how this research on psychological and social factors relating to adolescent self-harm fits within the context of wider research in this area. The methodology will be reviewed in section 9.3., drawing attention to strengths and limitations of the research conducted for this thesis. This will be followed by suggestions of potential applications and future research.

This thesis aimed to (1) review the literature on self-harm, particularly focusing on community-based research with adolescents; (2) identify the prevalence of self-harm in an ethnically diverse, community-based adolescent sample in East London; (3) examine risk and protective factors for self-harm and (4) explore the attitudes to and subjective experience of self-harm perceived by young people within the context of being an East London adolescent.

A comprehensive literature review addressed the first aim. It summarised research on adolescent self-harm and emphasised evidence relevant to community-based studies with minority ethnic groups. The review was followed by a mixed methods study. Questions on self-harm were included in the longitudinal RELACHS study, and the qualitative study was developed and conducted for this doctoral research. This enabled examination of adolescent self-harm with a multi-ethnic sample using data from RELACHS, a school-based survey to inform the second and third aims.

The fourth aim was addressed with a qualitative study, in which individual interviews were conducted to explore personal accounts and meanings within the experience of self-harm for East London adolescents. The qualitative data collected provides unique insights as it includes adolescents who had self-harmed and never discussed the issue. This contributes to the literature through providing depth from qualitative research with a hard-to-reach community sample. These studies illustrate the value of mixed methods;

contributing to the understanding of this secretive phenomenon using different types of research at a population and individual level.

This thesis examined adolescent self-harm in ethnic minority adolescents living in London. Potential stressors may relate to specific communities or to ethnically diverse areas where different cultural groups live in close proximity (Neeleman et al. 2001). The present study offered insights into how self-harm may relate to experiences of acculturation by adolescents in an ethnically diverse part of London. These results have potential to inform service providers working with young people, particularly adolescents from minority ethnic groups. This research could also inform schools with high populations of minority ethnic groups about adolescents' views on the issues they face, how they are dealing with them, and self-harm.

9.2. Summary and interpretation of main findings

9.2.1. Quantitative study

This research included both longitudinal and cross-sectional analysis examining self-harm in an ethnically diverse adolescent sample. When interpreting this analysis, it is important to note that the associations are not deterministic in identifying risk factors for self-harm. The results from this study do not imply causality. Rather, these results indicate factors which are associated with self-harm in this sample of adolescents.

The main findings from Chapter 5 will be presented in this section, interpreted with comparison with previous research. This section will outline the relevance of findings including the prevalence of self-harm, followed by discussion of associations with demographic factors, psychological symptoms, interpersonal relationships and cultural factors. As the present research was conducted in East London, it makes a unique contribution by replicating previous findings with an urban, ethnically diverse sample in London.

Prevalence of self-harm in East London adolescents

Self-harm shows a similar prevalence in an ethnically diverse, socio-economically deprived London sample, compared with other community-based studies in the UK and Europe (Hawton et al. 2006;Madge et al. 2008;O'Connor et al. 2009). The lifetime prevalence of

self-harm meeting study validation criteria in this thesis was 14.7% in females and 3.2% in males. Compared with the present study, the lifetime prevalence of self-harm in the CASE study (Hawton et al. 2006;Madge et al. 2008) was lower for females (13.5%) and higher for males (4.3%). The twelve month prevalence of self-harm in the present study was 5.4% for the whole sample, (8.4% in females and 2.0% in males). This was similar to the 12 month prevalence in the combined sample from the multi-centre CASE study (8.9% for females, 2.6% for males). The twelve month prevalence in the present study was similar to, but somewhat lower than the results from the English branch of the CASE study (6.9% in total, 11.2% for females, 3.2% for males) (Hawton et al. 2002) and similar research conducted in Scotland (9.7% in total, 13.6% in females, 5.1% in males) (O'Connor et al. 2009).

This study used questions adapted from the CASE study (Hawton et al. 2006), including validation criteria when analysing open-text responses describing recent self-harm. The similarity in prevalence may indicate little influence of the socio-demographic characteristics which distinguish the ethnically diverse, socio-economically deprived RELACHS sample from other study samples.

Prevalence by ethnicity

There was some evidence for higher prevalence and risk of self-harm in Asian British participants. The participants who identified themselves as “Asian British” chose that mixed identity rather than assigning themselves to other South Asian groups (e.g. Bangladeshi, Pakistani or Indian). This implies that some influence of identification with being both Asian and British may relate to self-harm. This complements previous research with Asian adolescents (Bhugra et al. 1999c;Bhugra 2004). This finding of an ethnic difference was non-significant when the validated lifetime measure of self-harm was used. Thus some caution is required when interpreting this difference in prevalence.

Further exploration of this result was required to examine what it may be about being Asian British which might increase the likelihood of self-harm. Simply identifying the difference in risk between groups does not explain what might lead to those differences. Further analysis explored socio-demographic confounders which may be associated with both ethnicity and self-harm. For example, a recent study in Sweden reported that socio-economic disadvantage accounted for increased risk of self-harm in minority ethnic groups (Jablonska et al. 2009). That association was not evident in the present study.

The model of acculturation adopted for the exploration of cultural factors outlined in section 2.9.2.2. (Berry 1980;Berry 1997), suggests that strong identification with both host and traditional cultures may be a healthy acculturative style, and it is the combination of a stronger identification with the host culture at the expense of one's traditional culture which has potential to be problematic. This issue will be discussed further in the following section and relating to the qualitative study.

Acculturation

The analyses of cultural identity provide some evidence that acculturative style may relate to self-harm. Assimilated friendship choices (having more friends from races or ethnic groups other than one's own), were associated with increased risk of later self-harm. This may relate to rejection of family through rebellion against their ethnicity of origin. The absence of any cross-sectional findings, or any associations between marginalised acculturative style and self-harm imply that these findings should be viewed with caution.

This results implies some link between self-harm and a stronger identification with other cultures than one's own. However, a question remains about the validity of the assessment as it is difficult to assess the complexity of cultural identity with a brief quantitative assessment. Although the cultural identity assessments had been validated with adults from separate ethnic groups in East London (Bhui et al. 2005a), it is difficult to ascertain how adolescents from a wider range of ethnic groups may interpret the questions. Friendship choices may be influenced by the social and cultural mix within adolescents' school, neighbourhood and the wider community. Thus the responses to questions about friendship choices may relate to circumstance and exposure more than choices.

The theory adopted for this part of the study used a bi-cultural model, designed to explore the interaction of acculturative adaptation by a host and minority group (Berry 1997). Although this model provides a fundamental structure upon which to build theory, the simplicity may undermine potentially subtle differences between ethnic and cultural groups. For use within a multi-ethnic population, such as adolescents in East London, the model has a basic flaw as young people would be exposed to many groups, and the type of exposure to different groups may not be equivalent. Thus a more complex model may be required, potentially acknowledging that influences could stem from many sources.

There may also be limitations on these findings from a bias in sampling. Although schools were attended by young people from local catchment areas, it is possible that the mix of ethnic groups may differ between communities and schools. This potential sampling bias, with a dominance or absence of certain ethnic groups in particular schools may influence how participants responded to questions about the ethnicity of their friends in or out of school.

Socio-economic status

In this study, the absence of association between deprivation and self-harm is similar to the findings from other community based studies on adolescent self-harm (Hawton et al. 2006;Sourander et al. 2001). The associations shown at a service level may imply a relationship between social class and more severe self-injury that is not clear in the more common, but less severe self-harm identified at a community level (Ayton et al. 2003;Beautrais 2000;Hawton et al. 2003a;Jablonska et al. 2009). The associations between socio-economic status and attempted suicide in adults (Gunnell et al. 1995;Platt et al. 1988) also imply that risk factors for self-harm and attempted suicide may change throughout the life course.

This study contained limited information on socio-economic status, as it was only assessed by adolescent self-report. The lack of association between socio-economic status and self-harm may also relate to the lack of socio-economic variation within this sample, as reported in previous mental health research in this area (Stansfeld et al. 2004). Thus, this is not strong evidence against the role SES may play relative to self-harm and suicidal behaviours in general.

Mental health and psychological distress

There was strong evidence that psychological distress, including depressive symptoms and conduct problems reported at age 15-16 was associated with lifetime and recent self-harm. There is an inherent difficulty in interpreting the direction of the relationship between self-harm and psychological distress as self-harm may be an aspect of poor mental health, and also may have an impact on mental health after the event. It could be that one factor leads to another, and that like predicts like, or there could be common vulnerability factors, rather than causal relationships between factors such as depression and self-harm.

One third of those who self-harmed reported suicidal ideation. This is a substantial proportion; however, it shows that the majority of people who self-harmed were not

suicidal. The rate of suicidal ideation was lower than reported in the CASE study (59%) and recent school-based research in Scotland (39%), however, those studies were anonymous and cross-sectional (Madge et al. 2008;O'Connor et al. 2009). There may be some bias against reporting suicidal feelings as the present study was not anonymous. The frequency of suicidal ideation is concerning, however these figures provide evidence that non-suicidal self-harm is a common behaviour which warrants further investigation. The variation in suicidal ideation also has implications for potential responses to self-harm, and the need for varied service provision for self-harm in young people.

The role of current and previous mental health

Current mental health showed a stronger, more consistent relationship with self-harm than previous psychological distress, assessed by the SDQ. Cross-sectional associations between psychological distress and self-injurious behaviour have been shown repeatedly in young people (Hallfors et al. 2004;Hawton et al. 2002;Meltzer et al. 2001;Muehlenkamp & Gutierrez 2004;Ross & Heath 2002). Thus this study replicates known relationships in an ethnically diverse urban sample.

In this study, longitudinal associations were identified between previous depressive symptoms and self-harm in models which adjusted for current depressive symptoms. This replicates in the RELACHS sample (Lewinsohn et al. 1996;Young et al. 2006). The odds ratios for prospective associations between emotional symptoms and conduct problems decreased with adjustment for current mental health. As past and present mental health are likely to be related, this may imply that enduring or recurrent psychological distress may both relate to self-harm.

Sub-threshold psychological distress

Results implied that both cases and those with borderline scores for psychological distress had increased risk of self-harm, illustrating that self-harm is not solely associated with diagnosable psychological problems, but also with moderate sub-threshold levels within a community sample. This issue has been discussed in previous research (Hawton et al. 2006). Nonetheless further attention to the importance of sub-threshold associations could provide further insight into less medically serious self-harm which is prevalent in community studies of adolescents, and thus could be important for informing community-based interventions.

The significant relationship between previous depressive symptoms and recent self-harm in males but not females may imply that self-harm in young males is more clearly related to mental health problems, compared with sub-threshold distress relating to self-harm shown in analysis of the whole sample. The small number of males who had self-harmed in this sample limited further exploration of this finding however; this would be interesting to explore in future research.

Conduct problems and depressive symptoms

Both conduct problems and depressive symptoms were associated with self-harm in this ethnically diverse sample. Current depressive symptoms clearly showed the strongest association with self-harm. However, the presence of significant associations with conduct disorder indicate some role of externalising as well as internalising, as noted by Nock et al., (2006). Associations between conduct problems and self-injury have been shown in previous research, primarily in females (Beautrais 2000;Brent 1995;Garrison et al. 1993;Nock et al. 2006;Patton et al. 1997). The present results may indicate comorbidity of conduct and emotional problems. Alternatively, conduct problems could be an external expression of an internalising conflict, or propensity for impulsive behaviour.

Social support

Cross-sectional analyses showed that low social support from family was associated with an increased risk of self-harm, in agreement with previous community-based longitudinal research (Borowsky et al. 2001;Lewinsohn et al. 1996;McKeown et al. 1998). Social support from other sources did not have such consistent associations with self-harm, emphasising the importance of family support for young people. It is feasible that mixed results regarding social support could stem from variation in close relationships. That is, some relationships could be supportive, whereas other close relationships could be very unsupportive, or have a destructive influence on the young person.

The results relating to support from family were complemented by the associations between parental style and self-harm. Low maternal and paternal warmth and high maternal strictness were associated with self-harm. The association between self-harm and both a lack of warmth and harshness from parents could be interpreted to indicate a form of self-punishment, acting out internalised harsh treatment the young person may have received from a parent in the form of harsh treatment of themselves (Sandler et al. 1992).

These results highlight the important role of social factors in self-harm, moving the emphasis of attribution away from a medical or psychological model. The strong associations with social factors imply that a more systemic approach may be required when addressing self-harm. That is, assisting the individual within his or her social context, with potential involvement of the social network in alleviating distress.

Bullying

Being the victim of bullying was associated with self-harm, replicating previous community-based research (Baldry & Winkel 2003;Borowsky et al. 2001;Hawton et al. 2002). As the assessments in this study related to lifetime bullying and lifetime self-harm, it was not possible to identify longitudinal associations. People who have self-harmed may be more likely to report bullying as a justification for their behaviour, which may have an influence on apparent associations in retrospective analyses.

Adverse life events

A greater number of adverse life events were associated with increased likelihood of self-harm. The rates of life events seem relatively high compared with other studies addressing prevalence of childhood adversity (Wainwright & Surtees 2002). This may relate to the nature of the sample in RELACHS, or may relate to the nature of life events assessed. For example, parental arguing was a commonly reported life event which may not be severe, and may be expected to occur more frequently than an event such as family bereavement. As these were self-report closed option questions, it is difficult to ascertain how the questions were interpreted. It is also possible that events such as parental separation or divorce may have been included if parents were already separated, rather than having separated during the past year. Although this study does provide evidence for the association between life events and self-harm, weakness in the assessments imply that the evidence should be reported with caution. The examination of adverse life events did not include exposure to suicidal behaviour in others, which might be a particularly important life event to consider in future research on self-harm.

9.2.2. Qualitative study

The results from the qualitative study include young people's accounts of self-harm, within the context of their views on identity, relationships, community, health, stress and coping. The interviews were analysed to present detailed accounts describing their experiences, with some more explanatory interpretive analysis. This thesis provides evidence about the

diversity within self-harm at a community level, including the scope for different aspects of self-harm to fit within different theoretical conceptualisations of the behaviour. The variation in accounts highlights the importance of acknowledging the individual point of view or experience, and difference in the roles the self-harm may play for each person. Although highlighting this variation is not a novel finding, these accounts are couched within the lives of young people growing up in East London. Such information could be beneficial to people who work with young people, in terms of knowing how the issues might be spoken about, if they were disclosed. Including the context and each person's explanatory model of self-harm incorporates socio-anthropological ideas into the discussion of a person's illness experience; what they experienced, and their beliefs about the causes (Bhugra 2004).

This study used individual interviews to explore adolescent perceptions about self-harm, providing more in depth data from a community sample than previous research. Other studies have used open-text data from surveys which provided some insight into motivations for adolescent self-harm and help-seeking (Fortune et al. 2008;Rodham et al. 2004). The need for interview data to provide a richer exploration has been noted (O'Connor et al. 2009). Other qualitative research has provided in depth insight into self-harm, however, these have often recruited participants from a health service context (Redley 2003;Reece 2005;Sinclair & Green 2005) or over the internet where potential participants were already communicating with others about their self-harm (Adams et al. 2005).

The present study included accounts from young people who had self-harmed and had never spoken about their harm before, making this a unique sample. This study also sampled young people who had not self-harmed, providing social context for discussion of adolescents self-harm. Definitions of self-harm varied between participants and the research literature. The stigma around the term "self-harm" influenced how harming behaviour was discussed.

Definitions and perceptions of self-harm

The term "self-harm" was known to the majority of participants, illustrating that although this was a secretive behaviour, it was a familiar concept. Being known, it was deemed as something one might try; potentially normalised as an experimental behaviour. This may indicate that for some young people, self-harm functions as an experimental adolescent

behaviour such as smoking, as noted in previous quantitative research (Ross & Heath 2002).

Despite being aware of the phenomenon, young people did not necessarily relate their own self-injurious behaviour to that term. The reluctance to identify with the label of "self-harm" was evident in both the pilot and main qualitative study. This may imply that adolescent definitions of self-harm did not include actions they had taken, or that they did not wish to admit to themselves that they had self-harmed. Changing identification with risk behaviours has been reported to vary in adolescent survey-based research, influencing how such behaviours are reported over time (Rosenbaum 2009). Not wishing to identify with having self-harmed is reminiscent of findings from research about depression in young people, where reluctance to seek help was partly attributed to avoidance of being given a diagnostic label and admitting they were not well (Biddle et al. 2007).

Definitions of self-harm from young people included a wide variety of behaviours such as wall-punching, cutting and self-battery. Wall-punching was viewed as a way to express anger and not always viewed as self-harm. The functional value of self-harm, expressing or releasing emotion therefore includes "acceptable" behaviours, lacking the stigma attributed to other forms of self-harm with more symbolic value, such as self-cutting. As views on self-harm and recall of the experience could change with hindsight, it is difficult to explore how self-harm may feel "at the time".

Exposure to violence or fighting may normalise self-harm It is also feasible that there is also a link between moving from feeling persecuted by others, to becoming the aggressor, even if their aggression was taken out on oneself. The sense of release which accompanied externalising feelings may relate to a change from having nothing tangible to having something to show for their pain.

People who had not self-harmed did not find self-harm easy to understand, and some viewed it as a highly unacceptable behaviour. Despite familiarity with the idea of self-harm, those who had not done it did not view self-harm as a normal coping strategy.

Precipitated by many things

Self-harm was attributed to many different feelings and situations, illustrating no clear pattern of causality between precipitating events and actions. Although there were no consistently reported triggers prior to self-harm, some people expressed a desire for pain,

or release, implying an existential aspect; needing to see blood or bruises, to feel strong, or that their feelings were real.

The accumulation of challenging emotions, situations and events were described as pre-empting self-injurious behaviours. Common precipitants related to family problems and a lack of emotional availability from family members. Descriptions of escalating pressures which felt beyond the participants' control could be conceptualised as a sense of "entrapment", as proposed by Williams (1997). This model describes self-harm stemming from a sense of having no escape, relating to a short or a long-term situation, in which an individual perceived they had little power over their circumstances.

Parental conflict and separation were discussed in the qualitative study. Such events have been noted as increasing risk of suicidal behaviour in adolescents (Beautrais 2000;Reinherz et al. 1995). Evidence from the present study implied that it may be family conflict and stresses associated with separation which may relate to self-harm, not simply the state of living with a single parent.

Reports from young people who harmed themselves because they could not harm the problem or person who upset them, could be interpreted within a psychoanalytic framework fitting with that outlined in Freud's *Mourning and Melancholia* (1917). That is, if the young person "internalises" or identifies with the person (the object) they are angry with, and wish to hurt it, then hurting themselves could function as a means of hurting that object (Bell 2000;Williams 1997). The conflict between a sense of duty and a sense of resentment towards family featured when contextualising self-harm. That is, young people described hurting themselves as a way to deal with feelings deemed unacceptable if they were angry with a parent for being absent, unwell or emotionally unavailable. This may also relate to depressive thinking, wherein a young person may blame themselves, or have a sense of responsibility for family situations or relationships.

Modelling and expressing distress

Exposure to self-harm functioned to make it an option; if others were doing it, the young people in this study could do it too. Exposure to and clustering of self-harm have been discussed in terms of social modelling in community-based research (Muehlenkamp et al. 2008). This has implications for potential interventions as the process of social modelling

could be used to increase understanding about self-harm and to expose young people to other more adaptive ways of coping.

Data from this qualitative study implied that although some adolescents experiment with self-harm, exposure and experimentation do not necessarily explain self-harm among those who adopt it as an ongoing coping strategy. That is, the explanation of social modelling may be appropriate for some self-harm, but does not explain all self-harm. Those who viewed self-harm as an option, learnt from others, used the behaviour differently from those who described a more acutely distressed dissociative experience of their initial self-harm.

Young people who self-harmed when severely distressed and desperate to express themselves tended not to mention a role of social modelling when starting or repeating their self-harm. There may have been some influence of normalising the behaviour through exposure from others, however, that was not a feature of accounts detailing self-harm as a personal response to distress. Theoretical accounts of self-harm need to include the notion of self-harm as an experimental behaviour, normalised through exposure, as well as an expression of extreme emotional distress.

Expressing anger

Both male and female participants spoke of self-harm as a way to express their anger. Self-harm as a manifestation of adolescent anger has been discussed by previous researchers (Hawton et al. 1999a;Pattison & Kahan 1983;Ross & Heath 2002). Anger may be a more acceptable expression of distress than sadness or fear, particularly in young males. For example, punching walls may be an acceptable outward expression of aggression. Applying Williams' "cry of pain" model, it is possible that less serious suicidal behaviour, including angry self-harm may reflect a form of "protest", about a situation, in which options to escape or cope are perceived as limited (Williams & Pollock 2000). The hopelessness associated with depression and more serious suicidal behaviour may develop with the perception of having no acceptable options to deal with a situation.

Repetition and cessation

Self-harming may be repeated over a long time, or may be time limited, attributed to passing stressors or a difficult period. Self-harm was described as both something young people stopped doing, and also as a response that they learned to rely on to deal with their emotions. The latter group described how the feelings self-harm gave them reinforced their

actions. Being able to distinguish these groups may have important implications for responses to initial harm, and application for clinical practice. However, this distinction may be difficult to ascertain from early or hidden self-harm. Previous research has reported that cessation of self-harm was associated with the dissipation or resolution of stress related to adolescence, and thus for some people without enduring psychological problems or chronic stressors, self-harm may have a short time course (Ross & Heath 2002;Sinclair & Green 2005).

The conceptualisation of self-harm as a self-destructive period at a time of crisis provided a contrast to self-harm being viewed as separate episodes. Reporting of only harming "once" may indicate the limitations on what some young people were willing to admit to themselves, or indicating a hazy recollection of a distressing time. It has been noted that people who are depressed or suicidal are more likely to recall general memories than non-depressed controls, with the implication that general memories indicate a lack of emotional processing of an experience (Williams 1997). This could be an additional explanation for the lack of detail in recounting personal self-harming experiences.

Disclosure

Disclosure of self-harm was viewed by most participants as a negative experience, to be avoided if possible. Disclosure included intentional display or inadvertent discovery of self-harm. The desire to keep self-harm hidden fits conceptually with participants' justification for self-harm, as a response to keeping emotions and problems to themselves. It is feasible that reluctance to seek help may relate to previous experience or awareness of other people's experiences when their self-harm had been disclosed or discovered (Stewart et al. 2006). Alternatively, if self-harming was not viewed as problematic, it follows that these young people felt no reason to tell anyone else about it or to hide it.

There may be some variation between how different groups, such as peer groups, family groups or cultural groups view disclosure of personal issues or distress. Such norms may be implicit, or explicit, and may exert both push and pull influences on help-seeking behaviours (Fortune et al. 2008).

Some participants wished to use their self-harm as communication. Public display of self-harm was termed "attention-seeking" by others, a matter which has been discussed in previous research (Mental Health Foundation 2006). However, public display of self-harm could function as a form of "help-seeking", which although achieved by the same means,

does not carry the same negative connotations attached to “attention seeking”. Seeking attention could also imply some desire for help or support. The National Inquiry into Self-Harm among young people also reported a reluctance to disclose self-harm for fear of the response it might receive, and that disclosure had not been a positive experience (Mental Health Foundation 2006). The results from the study within this thesis provide evidence to complement the broad range of methods included in the National Inquiry.

There was evidence in this study that for some people, display or discussion of self-harm was a central motivation for their actions. The outcome of self-injury could function as a communication, without necessarily having communication as the main motive, thus functioning as a “cry of pain” (Williams 1997). The variation in accounts illustrated that for some participants, harm was a solely a private “cry of pain”, whereas others harmed as a “cry for help”; and a third group integrated both motivations, as discussed in previous community-based research (Rodham et al. 2004;Scoliers et al. 2008). Young people discussed wariness about trusting others, irrespective of self-harm status, and also an awareness of presenting different aspects of themselves to others, which has been noted in previous research on self-harm in young people (Adams et al. 2005).

Social networks and help-seeking for emotional problems were included to provide some context when exploring the disclosure of self-harm. Participants in this study explained a preference for discussing any problems with friends, not only self-harm, providing some context for findings about disclosure of self-harm. Young people being most likely to tell friends about self-harm has been reported before (Coggan et al. 1997;DeLeo & Heller 2004;Evans et al. 2005;Fortune & Hawton 2005b), with the note that it is developmentally appropriate (Fortune et al. 2008). One main difference between talking about self-harm and other problems, was that self-harm had potential to provoke a response combining a reaction to the physical injuries, in addition to the distress shown by the person hurting him or herself. Participants implied that other problems may be acceptable to discuss, whereas self-harm was not. It is feasible that friends might be less judgemental or extreme in their response to self-harm, compared with parents.

In this study, the presence of a social network did not necessarily promote help-seeking or disclosure. Thus the suggestion that social isolation is a key aspect of not seeking help (Evans et al. 2005) was only relevant for some accounts within this study.

Those who had not self-harmed demonstrated that although young people may be aware of self-harm, it was not easy to understand, and disclosure may not be well received. These findings emphasise the need for increased awareness about self-harm, and ways to respond sensitively, should self-harm be disclosed. The findings from this study are in agreement with previous research highlighting a need to respond to problems leading to self-harm, and not simply address the injuries (Mental Health Foundation 2006).

Help-seeking

As this research was conducted at a community level, it explored factors relating to self-harm in young people who had not sought or received help. This provides insight into attitudes of potential service users and how help may be viewed prior to any engagement with services. For example, knowledge that school counsellors lived in the local community and thus may be connected to these young people socially was noted as a barrier, as was the perception that providing emotional support was not a part of a teacher's job. This study provides some explanation of how school counsellors are perceived, and justification of reluctance to approach them from the perspectives of school pupils. Some participants assumed that school staff would not keep problems confidential, and therefore did not trust them. The distrust of school-based services or counsellors has been noted in prior research (Evans et al. 2005).

Help was interpreted as containing two components; seeking help for the physical injuries and seeking help for the distress accompanying the injuries. An area for the application of this research was the fear that only physical injuries would be attended to, and that seeking help would entail being told to stop harming without being given support or justification.

Young people's perspectives provide further understanding about why self-harm is difficult to discuss, reinforcing the barriers to help-seeking. The difficulty in describing the experience of self-harm may illustrate that these young people did not have a sufficient understanding of their problems to be able to verbalise them. Help-seeking may be inhibited by a lack of knowledge about who would be able to help them outside of their social network, or about how a service may be beneficial (Wright et al. 2005).

There was no consensus about sources of formal help, or knowledge of potential gatekeepers such as general practitioners. This reflects other self-harm research in which a minority of adolescents suggested seeking help from professionals (Fortune et al.

2008;O'Sullivan & Fitzgerald 1998). Concern about whether approaching someone in a helping role would be beneficial, and belief in coping on one's own have been highlighted in self-harm research, and also in broader research on help-seeking for psychological distress in young people (Biddle et al. 2007;Fortune et al. 2008;Nada-Raja et al. 2003).

The initial trauma of having self-harm reported to others was later overshadowed by the acknowledgement that the support had been helpful in addressing the issues underlying self-harm. The mix of experiences from this study may explain the contrasting findings from other community-based research; that prior experiences did not have a strong influence on help-seeking (Fortune et al. 2008), along with reports that young people found service contact beneficial in retrospect (Burgess et al. 1998;Mental Health Foundation 2006). Within this study, those who reported positive contact with services were discussing the matter with hindsight, after they had ceased or reduced their self-harming, with the assistance and support of services. The acceptance of input from services following a positive experience is not surprising; however, it again highlights the inconsistency and range of experiences included within an exploration of adolescent self-harm.

There was limited medicalisation of self-harm, seeing it as a psychological or psychiatric problem, or even discussion of the relationship between physical and emotional pain. That was only evident in accounts from young people who had received input from services. That finding implies that young people view, or at least describe these behaviours differently to health professionals, and thus when planning services or interventions, this difference in understanding requires consideration. This has been noted in the literature on help-seeking for depression in young people, highlighting differences in perceptions of what might be helpful between population samples and service providers (Burns & Rapee 2006;Wright et al. 2005).

A lack of medicalisation may relate to how young people interpret their experiences. It may also relate to culture, as noted in research on ethnicity and self-harm in Manchester and London where South Asian women reportedly normalised depressive symptoms and explained self-injury in the context of relationship difficulties, rather than within a model of mental health (Bhugra 2004;Cooper et al. 2006). This study did not find patterns differentiating ethnic groups relating to help-seeking. This result is similar to recent analysis of research on adolescent self-harm in the Oxford area (Fortune et al. 2008).

Culture and self-harm

The qualitative interviews were designed to explore self-harm within the context of life as an adolescent in East London. With this design, there was scope for participants to present culture as a key feature of their self-harm if they believed that was the case. However, this pattern did not emerge and culture was not depicted as a coherent and definitive precursor of self-harm by these young people.

Culture was depicted as limiting perceived options for dealing with situations young people faced. Emphasis was placed on restrictions they associated with culture. This included, for example, limitations on what they were allowed to do with their time, on whom they were allowed to talk with and awareness of family reputation. There was no evidence that self-harm was seen as more or less acceptable by any cultural group.

Previous transcultural research with young people who self-harm has identified some associations with cultural conflict (Bhugra et al. 1999c;Merrill & Owens 1986), and this qualitative study provides some possible explanation about how and why those associations may occur. The descriptions of family and community pressures, along with emphasis placed on reputation within this study reflect comments from Asian adolescents about feeling compared with others (Bhugra et al. 2004). A similar commentary could be couched within discussion of identity within collectivist cultures, where a shared identity, potentially including family and wider society would imply that harming oneself was also harming others (Bhugra 2004). Ethnic and cultural background factors may relate to the influence of culture on self-harm; however, references to restrictions and cultural identity were not consistent. This highlights intracultural variation, and the importance of family factors, irrespective of ethnic or cultural group.

This sample included first and second generation migrants as well as adolescents of mixed race. Although stressors relating to migration may be particularly difficult for young people (Goddard et al. 1996), they were not emphasised within the relationship between culture and self-harm in this research. Cultural conflict was depicted as stemming from within families, due to greater or lesser acculturation while living in England; or as stemming from parents with different cultural heritage from each other. Different cultural influences within families may function in a similar way to a difference between one's own family and the wider community.

Family conflict was related to culture in some accounts, for example in the case of parental arguments being prolonged due to cultural disapproval of divorce. Thus the exacerbating role of culture on adolescent stress could directly relate to their behaviour, and also function indirectly, as an influence on the behaviour of others around them. South Asian adolescents highlighted culture as an area of conflict with parents in previous research (Handy et al. 1991). This issue emerged in the present study, but only as one of a number of issues which may have led to distress preceding self-harm. The role of cultural values potentially influences perceived acceptability of actions. Sensitivity is required in service provision and promotion for close-knit communities.

9.2.3. How do the quantitative and qualitative results fit together?

Self-harm is a complex, varied behaviour. Thus, exploration of self-harm itself and the role it plays for young people requires a range of approaches, seeking out different types of information to increase understanding about this multi-faceted issue. Quantitative and qualitative methods provided insight into different aspects of aims and research questions about the experience of adolescent self-harm.

Mixed methods broadened the scope of the research, with the self-contained quantitative and qualitative studies providing complementary findings (Lewis & Ritchie 2003;Pope & Mays 1995). The two studies produced data that was very different conceptually. The quantitative study operated at a population level with scope for statistical generalisation.

The validity of the qualitative study stems from the depth within the accounts, and the range of insights described. That is not a claim of theoretical generalisation, but rather that the contents within the interviews may reflect views young people in secondary schools may have about self-harm. This qualitative research has scope for “representational generalisation” in terms of presenting a range of accounts which could be inferred back to individuals from the population from which the sample was drawn (Lewis & Ritchie 2003).

The qualitative research in this thesis was not intended to explain the results from the quantitative study; however, it could offer some possible insight when interpreting associations. That said, individual accounts would not be expected to correlate with predictions from a positivist population-based survey. However, the quantitative study did inform parts of the topic guide to be explored within the qualitative study. An adaptation of

the survey methods were also employed to conduct the sampling questionnaire, facilitating the selection of a purposive sample to interview.

This section will discuss the topics for which both the population level and individual level analyses provided complementary findings. The results of the mixed methods research in this thesis cannot be merged beyond a commentary on findings arising in both studies. Examples to be discussed included mental health, relationships with family and the role of culture.

Differences in reporting self-harm by study methodology

A difference was evident in the reporting of self-harm in questionnaires and interviews. The difference illustrated that questions may be misinterpreted. Reports of "self-harm" from the screening questionnaire were described as accidental in interview, thus implying that survey data may show an inflated prevalence of "intentional" self-harm. This issue has been mentioned in previous research, and noted as evidence for the need to use multiple methods when researching self-harm (O'Sullivan & Fitzgerald 1998;Ross & Heath 2002). From a methodological point of view, however, the difference in reporting self-harm in the main RELACHS study and the pilot indicated that participants may be more willing to disclose self-harm in a survey than face-to-face. This is not surprising, given the secretive nature of the behaviour, however, it is pertinent to consider when planning future research. Although it may be more confronting to be asked face-to-face about self-harm, individual interviews provide more scope for personal reassurance about confidentiality, study motivations and potential referral than in a classroom group survey setting. In the main qualitative study, this issue was addressed by ensuring participants knew that researcher was aware of their self-harm status at the start of the interview, by giving them their screening questionnaire and asking for their comments on the research being done.

Internalising and externalising behaviours

The association between self-harm and mental state is well established. Self-harm may be viewed as a feature of poor mental health, or an expression of psychological distress. This research provided some evidence about the nature of distress associated with self-harm, relating to both internalising and externalising.

From the quantitative study, the associations between self-harm and both depressive symptoms (using the SMFQ) and emotional symptoms (using the SDQ) illustrated internalising, and containment of emotions. The externalising aspect was illustrated by the

association between self-harm and conduct problems (using the SDQ). These issues arose in the qualitative study, with participants explaining their desire to keep their problems and emotional expression to themselves, yet also encompassing externalising behaviours, such as aggressive wall-punching and outward expressions of anger, leaving visible marks. The part-public, part-private nature of self-harm reflects a combination of both inward and outward expressions of emotion.

Emotional availability of family

Both the quantitative and qualitative studies showed evidence for the importance of emotional availability of parents in relation to self-harm. In the quantitative study, lack of parental support and warmth were associated with self-harm. The same issue was explained by participants in the qualitative study, emphasising the importance of emotional rather than physical proximity of family. Lack of parental warmth has been noted in previous research (Bhugra 2004;Taylor & Stansfeld 1984). Linking poor emotional availability and support from parents with self-harm is coherent with an attachment theory model, explaining psychological distress in terms of insecure attachment style in these young people (Bowlby 1988).

Self-harm as a coping strategy

Throughout this thesis, self-harm has been referred to as a coping strategy, attributing behaviours to the individuals who enact them. The model of coping in response to appraisal of stressors relates to both individuals' perceptions about a situation, and their capacity to react (Folkman & Lazarus 1988). Previous research has emphasised the links between self-injurious behaviour in young people and their perception of limited options when approaching problems (Evans et al. 2005;Hawton et al. 2006;Lewinsohn et al. 1996;McLaughlin et al. 1996).

This study presented self-harm within a perception of limited options, when thinking of potential solutions to problems. The quantitative study provides a limited number of conclusions about self-harm as a way of coping. The main reason given for self-harm was "to get relief from a terrible state of mind". The qualitative study included accounts where participants felt they did not know how else to express themselves, and felt that they did not have other means of dealing with their feelings. These accounts fit within the coping model as they described actions being limited by beliefs about their social roles, and what they should or should not do. It is plausible that participants' inability to identify precipitants

of self-harm represented an inability to see their problems in perspective to deal with them in more constructive way than self-harm.

Culture in relation to self-harm

Results relating to culture have been interpreted with caution; however, there is some evidence for a role played by ethnicity or cultural stresses from both the quantitative and qualitative studies. The quantitative study showed a higher prevalence of self-harm in Asian British participants. In the qualitative study, there was evidence of culturally-related stressors. Participants spoke of family reputation and restrictions on how both they and their families were expected to behave, with reference to culture. This has been interpreted to illustrate that cultural stressors may exacerbate other adolescent stressors. However, these results also raise the issue of whether it is feasible to assess "cultural stressors", without tailoring assessments to specific ethnic or cultural groups, or using more in-depth qualitative methods as has been done in previous research (Bhugra et al. 1999c).

9.3. Discussion of methodology

This section presents a discussion of the literature review, the design and methodology of the two studies conducted for this thesis. Particular attention has been paid to strengths and weaknesses in the methodology and issues which arose arising through the process of conducting the research. This includes reflection on factors which may have influenced the quality and nature of the findings.

Literature review

This research was conducted shortly after a systematic review had been published on adolescent self-harm (Evans et al. 2004). This review informed the comprehensive literature review for this thesis, highlighting that although there is a growing body of research on attempted suicide, there is need for further research, particularly to increase the understanding of self-harm at a community level and in minority ethnic groups. The review methodology emphasised key longitudinal and cross-sectional studies with community samples of adolescents. However, due to the limited research on self-harm with minority ethnic groups, studies with adults and adolescents recruited through services addressing self-harm in minority ethnic groups and using qualitative methods were also considered to inform the empirical research to be conducted for this thesis. Additionally, as

the review was conducted prior to analysis of quantitative data and the design of the qualitative study, relevant publications which may have influenced the analysis plan or study design (Fortune et al. 2008;O'Connor et al. 2009) were not included in Chapter 2, however, such recent publications have been included in the discussion.

Definition of self-harm

Adopting a broad definition of self-harm may be a limitation, as it may be difficult to apply findings relating to a wide range of behaviours which have varying severity and acceptability in society. For example, the inclusion of ambiguous behaviours such as wall-punching within the definition of self-harm may diffuse findings that may have stronger relationships with deliberate self-cutting or overdosing; and vice versa.

The broad definition was important for the exploratory nature of this research, noting the breadth of self-harm as an issue for young people. It facilitated examination of why people hurting themselves did not wish to view their behaviour as 'self-harm'; including stigma about 'self-harming', ideas about 'why people self-harm', denial about their actions and defining the behaviour as something else, such as punching walls to feel strong.

Discussion of school-based research

Both studies in this thesis were based in secondary schools. Conducting research in schools facilitates access to a community sample as well as ensuring that young people are approached within a familiar environment with established support networks. The burden on schools and the amount of class time pupils would miss to participate are important to consider in school-based research. Demands on schools are great, and it is feasible that schools may be reluctant to participate if approached numerous times.

For both studies, data collection was influenced by the availability of the schools. Pupils were nearing the end of secondary school when RELACHS Phase 3 quantitative data was collected and also when the qualitative interviews were conducted, two years later. Not being allowed out of class or not wishing to miss classes important for exams may have reduced participation. Reluctance to participate in the study or answer questions on self-harm is an issue worthy of further exploration, however, reluctance to answer questions about themselves may not have been the main reason for pupil non-participation.

Input from liaison teachers was an essential aspect of school-based research. Teachers functioned as gatekeepers for pupil participation. If teachers were interested in the

research, that could be a distinct advantage of this approach and increase engagement. However, if teachers were too busy or not engaged with the research process, there may be reluctance for the school to participate or a lack of assistance when arranging school visits. Variation in responses from schools may introduce some selection bias into sampling at a group level.

The issue of confidentiality from teachers was raised repeatedly within this research. Reporting of contentious issues such as self-harm may be reduced if participants believed that teachers were involved in the research process and that disclosure would lead to them being followed-up.

Mixed methods design

The mixed methods design in this thesis facilitated comprehensive exploration self-harm using complementary methodologies and perspectives. The temporal gap between the two studies in this thesis may have influenced results. As the quantitative data was collected in 2005 and the qualitative data was collected in 2007, participant responses may have been influenced by issues pertinent at the time when the studies were conducted.

9.3.1. Discussion of quantitative methodology

This section presents a commentary about strengths and weaknesses of the methods employed in the quantitative study in Chapters 4. This includes comment on the design, sampling, procedure, assessments and analysis, all of which could exert some influence the findings in Chapter 5.

Design

The quantitative data in this thesis was a part of a larger cohort study (RELACHS). Thus the design had a strong theoretical background, and the study was conducted according to protocols established by an experienced steering committee (Stansfeld et al. 2003). As the questionnaire was designed by a mutli-disciplinary team, there were limitations on the depth of questions in the survey as a wide range of physical and mental health topics were included. Additionally, the inclusion of self-harm within an established study limited flexibility in design. For example, the statistical power was not able to be altered through sample size, as the sample had already been selected.

Sampling

Despite being recognised as a relatively common behaviour, a prevalence of approximately one in ten adolescents still presents some difficulties for recruitment of a research sample. For community-based work, large numbers of participants are required to identify people who self-harm in sufficient numbers for analysis.

RELACHS was designed to be representative of adolescents attending comprehensive secondary schools in the Boroughs of Newham, Tower Hamlets and Hackney. Inviting young people attending Pupil Referral Units was an attempt to make the sample more inclusive and representative. School-samples might be conservative as those who are less well may not attend mainstream schools (Shaffer & Gutstein 2002), however, as year 11 is the last year of compulsory education in the UK, it is likely that the sample would reflect the wider community, and so is less biased than samples of students attending 6th form college or university. The ongoing relationship with schools engaged with the study assisted methodological rigour, incorporating teachers and contacts at the local authority to help locate pupils who had moved class or school.

Sample attrition may have introduced some bias into the data by Phase 3, particularly as East London is an area of high social mobility. It is feasible that some of the young people with more enduring physical or psychological problems were no longer attending mainstream schools or pupil referral units, thus the associations found in this analysis may be conservative. However, this may not change the overall pattern of findings across the whole sample. An additional attempt to address sample attrition was the inclusion of missing data as a predictive category in statistical analysis, with the aim of maximising the available data.

Weighting was calculated for the data, to account for unequal probabilities of selection in the design. The prevalence of self-harm was not changed substantially by the weighting and thus the unweighted analyses were interpreted to indicate a meaningful prevalence of adolescent self-harm in pupils attending secondary schools in the three participating London boroughs.

Procedure

The surveys were conducted under exam-style conditions, in the same way at each phase of RELACHS (Stansfeld et al. 2003). This was important for the integrity of the data being collected, and is a strength of the study. The data for this survey was only identifiable by code, cleaned for consistency within responses and organised for analysis as a part of the wider study.

Assessments

The quantitative study used standardised methods when conducting school-based research to increase the validity of this research. The assessments were age-appropriate and where possible, validated for use with young people.

One key limitation was that the data for the quantitative study was all self-report. Self-report questions, especially those asking about lifetime experiences such as self-harm may be subject to recall bias. Self-report surveys of adolescents have been noted to vary over time, with the proposal that adolescents respond to questions according to their current identities, potentially misrepresenting different values held in their past, should their views have changed (Rosenbaum 2009). Although responses may be transient, does imply that they are not valid at that time. This issue is relevant for topics such as perceived social support. For example, the assessment of perceived social support (MSPSS) asked about a 'special person' (Zimet et al. 1988). The identity of this special person may vary, making analyses difficult to interpret.

There may be confounding influences on questions in self-report measures which are difficult to identify with this type of research. For example, as both bullying and depression were self-report, it is feasible that someone feeling down may be more sensitive to feeling persecuted. Alternatively, feeling that people did not like you could be a feature of depression. There may be some recall bias, for example, if participants were distressed, that may influence the way in which they reported earlier life events or self-harm.

Assessment of ethnicity was a major component of this quantitative research. Ethnicity was assessed using an adapted census question, in which participants were prompted to tick any combination of responses from the list supplied. The interpretation of such questions could vary, an issue raised by participants during data collection when they were uncertain of which box to tick, for example, if their parents were from different backgrounds.

From a transcultural research perspective, this study is open to criticism as constructs assessed have primarily been developed in western countries, with western ideas about health and expression of health. However, it could be argued that all of the participants were living in East London, and thus would have some exposure to western concepts relating to mental health. An attempt was made to address this with the use of assessments validated, or at least used with young people of different ethnic groups (Bhui et al. 2005a;Hawton et al. 2006;Meltzer et al. 2000;Mullick & Goodman 2001).

The validation of assessments relating to ethnicity is only one component of validation. Caution is required when interpreting the mental health findings in the quantitative study as only the child report of the SDQ was used (Goodman et al. 1998). The scale therefore had lower sensitivity than if the other assessments had also been used. Although the SDQ has been validated more widely in different ethnic groups compared with the SMFQ, the validity of the single report scale should be noted when interpreting results.

Assessment of self-harm

One challenge in researching self-harm is the difficulty in assessment, as self-harm is defined as different things by different people. This issue was addressed in the quantitative study by using questions about self-harm from another large school-based survey, including validation criteria, placing the responsibility onto the researchers to define self-harm reported in the questionnaire (Hawton et al. 2006).

By asking participants to describe only their most recent episode of self-harm, this assessment may have excluded reporting of multiple methods of self-harm. Although some participants reported more than one method, the question was sufficiently ambiguous and thus not a reliable assessment of co-occurrence of different methods of self-harm.

The validation criteria applied to the assessment of self-harm enabled researchers to have more certainty about the identification of people who had self-harmed. Such validation removed some of the exploratory aspect of the research, limiting participant definitions of self-harm given in the survey. The sample reporting “validated” self-harm was too small for substantial analysis of self-harm in the preceding year. Analysis conducted on self-harm in the past year (without validation) maximised the data available, however, there is potential that the broader assessment introduced some error into the analyses.

A further criticism of the assessment of self-harm related to intentions. The closed-response options provided for participants to endorse had been developed with input from young people (Rodham et al. 2004). However, choosing from a list may have influenced responses and biased reporting of motivations. Researching intentions is, however, very challenging as people may not be able or inclined to recall their intentions.

Analysis

The design of the study facilitated both cross-sectional and longitudinal analysis of this community-based sample. Despite examining longitudinal data, the assessments did not facilitate examination of persistence over time, or short-term recurrence such as repeated depressive episodes. As previous and recent depressive symptoms are likely to be related, it is possible that including both in regression analyses could be an over-adjustment.

In the analysis, there was limited scope to stratify by ethnic groups, to explore effects by ethnic group. Rather, findings pertain to the analysis of this combined ethnically diverse sample. That said the absence of evidence for associations does not necessarily equate to evidence for the absence of associations.

The approach to the analysis included in this thesis may have influenced the findings. There may have been effects which were too small to detect in a sample of this size, indicating potential for Type II errors. However, as there was no correction for multiple tests in this thesis, such as the inclusion of a Bonferroni adjustment, the approach to analysis may have taken insufficient steps to minimise the Type I error rate and thus falsely identifying differences between groups (Field 2000a). Any study of this nature requires consideration of the balance between offsetting these potential errors. There are limitations on how this can be addressed within secondary analysis on a pre-existing dataset, given that sample size and variables in the analysis were already established. Additionally, analyses were designed to address each hypothesis, with some adjustment for confounding factors. Further multivariable analysis including different a different set of potential confounders, may alter the findings evident in the analysis.

Analyses were reported in terms of odds ratios, 95% confidence intervals and accompanying p-values. It is worthy to note that although this thesis has referred to a "significance level" of $p<0.05$, that cut-off is essentially arbitrary (Sterne & Davey Smith

2001). Interpretation of the strength of evidence is relative to the sample, the range within confidence intervals and the variables included in the analysis. Within this thesis, it has been highlighted where results are to be interpreted with caution due to wide confidence intervals around point estimates and results which are difficult to interpret, such as those pertaining to quantitative measures of cultural identity within a multi-ethnic sample (Bhui et al. 2005a).

9.3.2. Discussion of qualitative methodology

This section provides a commentary on the qualitative methodology presented in Chapter 7, including factors which could have an impact on the quality and impact of the findings for this study. It discusses the design, sampling, interview content, procedure and analysis, along with a section on reflexivity.

Design

Conducting a qualitative study with a community-based sample on a secretive, sensitive topic was challenging, and fraught with ethical and logistical difficulties. A sample of young people who had self-harmed, and had not sought help was difficult to locate, and also to engage with the research process. Conducting a pilot enabled both the methods and content of the research to be refined. The methodology was developed for this study, emulating previous research with young, potentially vulnerable people by situating qualitative research within schools (Ross & Heath 2002).

There were logistical and pragmatic limitations on the data collection due to school availability and time taken to obtain ethical and research governance approval. Time limits did not allow for a more iterative approach to data collection and analysis.

Conducting a single interview within a school lesson limited the time available to develop a rapport with participants. Despite this limitation there may have been some advantages of a single interview, such as trusting confidentiality as the doctoral student was an adult not associated with the school or a service provider.

As framework analysis was developed for policy-based research (Lewis 2003), it could be criticised for use in more exploratory social research. However, the systematic and transparent approach to data collection and analysis strengthen the research and illustrate

how these methods address the aims of the study and the thesis as a whole. Other researchers have scope to view, and analyse the data using this method. Framework analysis has been used in large scale studies and the breadth of the enquiry does not preclude it from enabling depth in the analysis. This method may lack the depth achievable through other methods, however, given that this study was part of a mixed-methods design, this approach was appropriate, as it did provide insight into how young people defined, viewed and spoke about self-harm.

The use of semi-structured interviews provided a somewhat standardised means of collecting interview data, and the topics to be explored relating to the process of self-harm and how it related to social and psychological factors. This loose structure would have influenced the nature of the data being collected, and the approximate time dedicated to each topic within the interview. There was flexibility in the interview style, however, there the interviews could have been conducted with less structure in the approach, allowing views about self-harm to emerge from more open questions, with an approach more akin to grounded theory. This is a possibility for future research. However, due to the potential vulnerability of the participants and the sensitivity of the topic, the structure functioned to reassure teachers and governance review panels about the content of the research, and what was going to be asked of the study participants. Taking a very flexible approach may create concern about ethical issues when working with such a sample.

Sampling and participants

There was a low rate of response, with the majority of schools not wishing to participate in the qualitative study, or not responding to the invitations to participate. This may be partly to do with the timing of the study, as the year 11s were nearing their mock GCSE exams. Alternatively, it may relate to the content of the study, not wishing to participate due to the burden on the school or having been over-researched.

The use of screening questionnaires worked efficiently and discretely to select a sample for interview, maintaining participants' privacy relating to self-harm. However, despite having a clear design for sample selection, the varied interpretation of the screening questions about self-harm illustrates a weakness in this methodology. The shift in self-harm status between the surveys and interviews illustrates difficulty in researching this topic, with variation between responses in a questionnaire and face-to-face. This issue was addressed and explored further within the interviews.

Some bias may have been introduced into the study as the screening and interviews were conducted during school hours, and required pupils to be allowed to miss their class. However, teachers confirmed that pupils of mixed ability were participating in the study, as requested by the researcher. Selection of a sample to recount personal experiences of self-harm was done with the aim of enhancing the validity of the qualitative information collected by relating it to believable “real life” experiences (Curtis et al. 2000).

As the sampling frame was decided upon prior to data collection, there was not scope to pursue deviant cases relating to issues emerging during data collection. The decision to aim for an ethnically diverse sample led to a range of ethnic groups being included, which provided a rich variety of views about culture, reflecting the diversity within schools in East London. The range of ethnic groups may have limited the scope to gain in depth insights about issues relating to specific ethnic groups, however, that approach could be adopted in future research.

Content of the interviews

Working with young people, and asking them to give accounts of their emotional experiences has inherent challenges. Piloting highlighted that the actual process of self-harm and difficulty in talking about self-harm as issues to explore in more depth. Some adolescents were more articulate than others, and some had more experience of verbalising their feelings than others. It is possible that some of the participants were not familiar with discussing emotions or abstract ideas about coping, as they operated with a more concrete approach. There may also have been some recall bias in accounts of lifetime self-harm, depending on when the episode had occurred. The stigma around self-harm may lead young people to portray it in a different light (Bhugra 2004).

The interview style facilitated some flexibility in approach to the interviews, enabling the researcher to enquire about the process of self-harm, including attitudes, triggers, harming behaviour and disclosure, within the context of coping. Exploration of participants’ day-to-day life, stressors and social networks provided contextual information for more specific questions about their experiences relating to self-harm. The interview style included scope for young people to raise the issue of self-harm, primarily in discussion of the screening questionnaire or responses to questions about coping with stress.

Providing the screening questionnaire as a prompt in the interview functioned to make the topics for discussion more transparent for the participants. That is, they were given time to

look at the questionnaire they had completed, and thus were reminded about what they had told the researcher. That could have functioned to address some of the power imbalance between the participant and the researcher, as all topics to be covered and the researcher's knowledge about the participant were tabled for both parties to discuss.

The presence of the screening questionnaire in the interview may have influenced how participants explained their experiences. It may have primed the contents of their responses, for example, highlighting issues to raise as stressful life events. For those who found it difficult to verbalise their feelings, it may also have been easier to point to a written statement than to find their own words. However, as the presence of the screening questionnaire clarified self-harm status to both the researcher and participant, there were both positive and negative aspects to that part of the design.

Accounts of self-harm may have been primed by the information about the study and the screening questionnaire. The qualitative study was titled 'Stress, mind and body' and coping with stress was explored early in the interview. Both of these issues may have influenced participants' descriptions of their self-harm. Informing participants about interview contents is a vital part of informed consent and in this study, self-harm was couched within other coping strategies in the information sheet and screening questionnaire. It is difficult to ascertain the extent to which accounts were tailored to suit participants' perceptions of what the researcher wanted to hear. The interview style and prompt may have limited what participants chose to mention of their own volition, however the extent of that is difficult to gauge.

By asking participants about their own experiences, rather than discussing an example or vignette in the interview, this research was able to access ways in which young people might recount their experiences to a service provider or teacher. Accounts may vary depending on the audience, however, this approach provided insight into how young people describe their experiences and self-harm.

The qualitative study included exploration of the context surrounding accounts of self-harm. For example, descriptions of general help-seeking and disclosure of distress provided a background for the information about self-harm, which had not been done as comprehensively in previous quantitative studies (Evans et al. 2005). The open discussion of self-harm by participants who had not hurt themselves provided insight into how a non-self-harming peer may react to disclosure of self-harm.

The topic guide was kept consistent throughout the data collection, however some topics were probed further in later interviews. Maintenance of the core topics enabled exploration of self-harm in the context of coping with stress with all participants. This semi-structured approach focused the study to explore these issues, however, it did not limit participant responses, that is, despite asking participants about the same issues, this approach did not dictate the participants' responses.

An assessment was included to address how participants felt at the start and end of the interview. The brief thermometer-style gauge of the impact of the interview was a basic measure, and the numeric differences in scores have little meaning, however, it was an attempt to explore issues raised in the process of ethical approval about the experience of participating in sensitive research. Ratings of the experience of the qualitative study provide evidence that the majority of interviews were not viewed negatively by participants. This may relate to actually talking about their experiences, however, further research would be required to ascertain whether the interviewer was cast into the role of a counsellor for some participants.

Procedure

Methodological rigour in conducting qualitative research assists in ensuring the robustness of findings (Lewis & Ritchie 2003). The qualitative study was conducted using standardised methodology, with clear guidelines for sample selection and a protocol for all field work. All participants were given the same written and verbal information at both the screening questionnaire and interview. The use of individual interviews enabled exploration of personal opinions, without the influence of peers, as might have been the case in group or paired interviews. Most interviews were conducted in teachers' offices, which may have exacerbated the power imbalance between the researcher and the participant and reduced the participants' trust in assurances of confidentiality.

There was insufficient time to adopt an iterative approach to analysis and data collection. However, reflective thinking about the emerging themes throughout the research process added some element of constant comparison while the study was undertaken. This allowed for conceptual development through the course of the study.

Analysis

Framework analysis was conducted systematically after all interviews were conducted. This enabled a detailed description of the accounts presented by young people to be compiled by the researcher, as presented in Chapter 8. As the study was aiming to describe and explore the accounts of self-harm in East London adolescents, this approach to analysis met the aims of the study. The benefits of using framework analysis include the scope to analyse the whole dataset together, addressing issues both across and between participants.

The results presented in Chapter 8 are descriptive accounts, analysed with the assumption that experiences and expressed motivations of participants are truthful accounts, accepted at face-value. By remaining close to the data, the quality of the accounts was preserved, analysing the phenomenon in the context provided by the participants, as the young people presented it, rather than only addressing a specific aspect of the data, or interpreting the data to generate theory (Lewis & Ritchie 2003)

To enhance the validity of the analysis, ten percent of the thematic coding and charting was checked by another researcher (MK). The cyclical process of data analysis; returning to participant accounts and exploring issues raised during data charting and interpretation, was adopted to verify the findings from this data (Lewis & Ritchie 2003). The use of quotes as evidence to support interpretations ensured that the analysis was true to the data, within the context of the accounts provided by the participants.

Reflexivity

When undertaking qualitative research, the researcher inherently influences the data by being a part of the research process; interacting with the participants, asking questions within interviews and also making interpretations through the analytical process (Liamputtong & Ezzy 2005). Characteristics such as age, nationality, gender, professional status, prior knowledge and experience may all influence the data collection and analysis. Consideration is required to ensure quality within the research process, given the circumstances (Mays & Pope 2000). In the analysis, I was aware of the need to avoid ethnocentricity and using my own culture as a comparative norm.

For this study, I presented myself a research student from Queen Mary, University of London, who had worked with schools for a number of years. I was an adult who was not a teacher, despite working with teachers. Being at university may have influenced the participants' perceptions of me, as some spoke of wanting to go to university, while others

talked about university as something people who were ‘not like them’ would do. The study being based in the Centre for Psychiatry was downplayed, and if asked, I told participants that I had a “background in psychology”. This was well received by the participants, particularly for those who were grappling with issues in the topic guide at the time. This does raise questions about whether participants viewed the interview as a form of counselling (Alty & Rodham 1998). I was clear about the fact that the interview was for research, and not involved with any service provision for young people in the area and that I was not exploring these issues as a counsellor.

My experience of providing emotional support through voluntary agencies including Samaritans may have influenced the style of the interviews. My aim was to maintain a friendly non-judgmental tone. It was difficult to ascertain how the content of the interview may have influenced subsequent behaviour, that is, whether accepting narratives and justifications about self-harm may have in some way condoned the behaviour. All interviews were followed by a debrief and discussion of potential help sources. I am not aware of any actions after the interviews in terms of self-harm or help-seeking. Having an Australian accent led to clear identification that I was not from the local community. That may have encouraged participants to explain more about how they saw their social context, as they did not assume I was familiar with social or racial relations in their area.

My approach was grounded in cognitive psychology, with an influence of working within a psychiatric epidemiology research department. This may have influenced my interpretation of the data and conceptualisations of depth. My aim was to conduct an exploratory piece of work, to remain open to ideas suggested by participants, and follow their thinking, rather than imposing my own theoretical structure on their accounts while conducting and analysing the interviews.

9.4. Ethical considerations

This section will provide a brief discussion of ethical issues raised during this research. Some issues were addressed in procedures and protocols of the studies within this thesis, while others remain open as questions to consider when reviewing the contribution of this work. Any research with vulnerable people contains additional ethical concerns about participant safety, however, research is required to increase understanding of which issues are pertinent to enable support and inform preventative measures (Alty & Rodham 1998).

If conducting such research, there is a need to illustrate that potential benefits justify the potential risks.

Ethical questions on studying adolescent self-harm may vary by research method, with qualitative research being scrutinised more carefully than quantitative research. Questions adapted from the CASE study (Hawton et al. 2006) about self-harm were approved for RELACHS in East London, without the requirement of referral upon disclosure of self-harm, which is suggested in child protection guidelines (London Safeguarding Children Board 2007). Thus the addition of self-harm questions to the quantitative study in this thesis was not challenged in the process of ethical approval. However, ethical challenges were levelled at the qualitative study for this thesis. The question arose about whether it was ethical, or even possible to research a secretive risky behaviour without jeopardising the safety and privacy of the young participants involved.

Confidentiality is imperative for rigorous research. However, when conducting research with vulnerable young people, the boundaries about keeping or breaking confidentiality come under question. Confidentiality was important to study participants. In contrast, breaking confidentiality may be important for the safety those young people (London Safeguarding Children Board 2007), despite being a somewhat paternalistic, disempowering approach.

Child protection issues were important in conducting this study, aiming to ensure the safety of participants while exploring their experiences of self-harm. One issue of conflict arose when considering the Pan London Child Protection Protocol (London Safeguarding Children Board 2007) which requires any self-harm to be referred for a multi-disciplinary risk assessment. As the present research was aiming to identify young people who had self-harmed, adherence to such guidelines would have inhibited the confidentiality offered to participants. That is, agreeing to participate and disclosing any recent or previous self-harm would have led to their self-harm being made public, which could also be seen as unethical.

Stigma about self-harm provides further complexity. If there is reluctance to participate in such a study for fear of being associated with self-harm at an area, school or individual level, particular care is required when attempting to explore the issue. A lack of understanding potentially fuels further stigmatised thoughts.

When aiming to conduct an exploratory study, it is important to allow the findings to emerge from the data provided by respondents. Thus the requirement for informed consent led to yet another complication. As young people's perceptions of self-harm were being explored, the term "self-harm" needed to be in the information provided prior to the study. This may have influenced responses. Participants were informed that they would be told during the interview if they were providing concerning information which would require a break in confidentiality, such as the implication that the participant was currently at risk of suicide, or at risk from other people. Such clarification required for informed consent may therefore have influenced what was said in the interviews. However, it would be unethical to invite participants to a study including self-harm without directly informing them beforehand.

This research was conducted in affiliation with secondary schools. Consent to work with the young people involved consent from local education authorities, head teachers and co-operation from school staff prior to contacting pupils and their parents. Using a parental opt-out form of consent is potentially questionable, as it is difficult to ascertain whether parents would have received information and opt-out forms. However as this research was exploring young people's opinions and experiences, their consent was deemed the most important. This is particularly relevant as a disparity has been shown between parent and child report of self-harm in young people (Meltzer et al. 2001).

This study addressed ethical issues by establishing protocols for risk. School-based services were requested to provide information for participants and a consultation panel including mental health professionals was contacted for advice when required. As there was no follow-up to the study, these actions were assumed to have been sufficient, however, without further scope to research the impact of the interview experience on participants or gatekeepers, this was difficult to gauge.

Finally, there is an ethical issue relating to the use of research such as this. That is, having identified self-harm in adolescents as a serious issue, it is important to continue research to increase understanding about it. Research is justified if it can assist in breaking down communication barriers, facilitate of support, and appropriate responses when young people self-harm. Without exploring the issue and the perspectives of the young people involved, it is difficult to develop appropriate services or interventions. It would be unethical to acknowledge the serious nature of this issue without attempting to research it further.

9.5. Implications and recommendations

9.5.1. Application of the study

This research presents insights using qualitative accounts from an ethnically diverse, socio-economically deprived urban sample of adolescents. Research conducted at a community level, provides a context for service-based research. Similarly, research with adolescents provides information about young people themselves, and also a background for research with adults.

9.5.1.1. Self-harm as a complex and varied issue

This study contributes to the understanding of self-harm as a complex, varied behaviour. Epidemiological research highlights factors which may be targeted in service provision and interventions. The qualitative study provided evidence that although some self-harm is likely to be repeated, and may lead to suicide, not all self-harm escalates. This implies that adolescent self-harm may lie on different trajectories. For example, for some young people, it may function as an experimental behaviour, or a short-term, maladaptive response to a crisis. The long-term implications of such behaviours are yet to be established.

9.5.1.2. Responses to disclosure of self-harm and justification of requests

Young people clearly asked to be listened to, should their self-harm become known to others. Although some people may wish to shock others with their self-harm, this study suggests that the majority would not. Participants expressed a desire to be shown respect if others found out about their self-harm, and for consideration of how they might feel if their disclosure was greeted with shock reactions from others. There was emphasis placed on a need to address the psychological and social problems that these young people faced, rather than simply responding to their physical injuries.

Support services need to consider that some young people self-harm due to a difficulty in articulating their feelings. Their limitations in expressing themselves may relate to personality, or perceived barriers. Barriers could include whether it was socially

appropriate to talk with a potential help source of a certain age, gender, ethnicity, with a certain role, or connection with their family.

In addition to wishing for consideration and respect, young people explained that it was difficult to simply be told to stop self-harming. Young people requested justifications when receiving input from others about self-harm. Those who had stopped explained that they needed justification about why it was not a beneficial behaviour, and why they should stop. Others sought justification about why it would be beneficial to either tell others, or seek help in some way. Additionally, young people requested justification for breaking confidentiality and who would subsequently be informed about their self-harm. In a school situation, young people would also have benefited from being told about how the issue would be discussed in front of other staff or pupils.

9.5.1.3. Identification with the term self-harm

Not identifying with the label “self-harm”, may have implications for practice, as service providers may be attempting to address an issue young people may not believe is relevant to them. It is debatable whether it would be beneficial to emphasise using the term “self-harm” in psychoeducation interventions. Research has shown that young people who recognise depressive symptoms, and use terms such as “depression” are more likely to endorse appropriate help-seeking and treatment preferences (Wright et al. 2007). This implies that the use of psychological or psychiatric labels may be beneficial, as identification of the issue may trigger appropriate behaviour to respond to the distress.

Young people presented varied interpretations of self-harm, and views on whether it was problematic. Such views may vary from how self-harm may be seen by a service provider. Thus, should a young person come into contact with services, clinicians may need to bridge the gap between their perspective on self-harm and that of the young person. Service providers may need to explore the explanatory model held by the young person and why they might have those views, with acknowledgement of potentially relevant factors such as culture, family, music or peers.

9.5.1.4. Role of family

Evidence from this research highlights the important role family life can play in the lives of young people and how they handle distress. In the qualitative study, comments were raised about how contact from a young person’s school may amplify difficulties at home.

Although there are sound reasons for involvement of family, it is also worth considering the situation where informing parents or family members may not be the most beneficial response for that child at the time. Care would be required when involving a young persons' family as it may also be against their wishes.

From care giving and intervention development perspectives, it would be ideal for family to be involved. However, if the distress reported by the young person related to lack of support or warmth from family, engaging family for the benefit of the young person may prove difficult.

9.5.1.5. Tailoring of services to local communities

Services in ethnically diverse areas need to consider that culture and cultural identity may influence health, and also the presentation of health. However, the question remains regarding what it is about culture which may influence those experiences or presentations.

Services need to consider lifestyles of local communities, particularly concerning young people living within cultural rules of different communities. For example, it may be seen as preferable to seek help from someone within their community, or alternatively, someone who was from a different background. The need to increase accessibility and decrease stigmatising barriers to help is an important implication from this study, if attention is to be paid to the needs of young people self-harming do not seek help.

9.5.1.6. Informing the development of a school-based intervention

The community-based findings from this study imply that there is potential for interventions based in schools. Schools may provide an opportunity for young people to express themselves away from family or cultural boundaries. Teaching about emotional awareness and self-harm could be situated within established health and social education. Schools provide an ideal situation for interventions as they provide access to a wide proportion of the population who are at an age where psychological problems and self-harming may begin (Hawton et al. 2006).

Basing an intervention in schools may facilitate help-seeking for self-harm within the school and linked services. Issues raised in this qualitative research include awareness and trust of support staff within schools, along with either not knowing what to expect, or not expecting their perspective considered.

The prevalence of self-harm, difficulty in disclosure and barriers to help-seeking indicate that there is a need for community-based interventions (Fortune et al. 2008;Hawton et al. 2006;O'Connor et al. 2009). Previous outlines for community-based interventions included addressing awareness about suicide and mental health along with skills training programs (Hawton et al. 2006) and targeting optimism and emotional literacy (O'Connor et al. 2009).

Couching self-harm within general emotional health and well-being

Issues identified by epidemiological research as risk factors may inform targeted services or interventions. The associations between sub-threshold psychological distress and self-harm illustrate that self-harm is not necessarily related to more severe mental illness. Both those with mild and severe psychological problems are important to consider for community-level interventions for self-harm.

It would be appropriate for a health education intervention to address broad aspects of emotional health, anger management and well-being, providing a context for self-harm. There is a possibility that a broad approach to emotional well-being may alleviate the distress leading some young people to self-harm. Peer education about recognition of distress in others and promotion of awareness of how to seek help and support may benefit those who need help themselves and could facilitate help-seeking in others. This is pertinent as young people are most likely to tell friends about self-harm or issues they face, and the peers may need support themselves, as well as information about how to respond.

Ideally interventions need to target high risk groups, however, the prevalence of self-harm implies that interventions addressing emotional health and anger management in young people may function in a preventative role. Similarly, interventions reducing the stigma relating to poor mental health and normalising help-seeking behaviours may play a role for both young people who self-harm and others around them who may be approached for support.

Balance between raising awareness and promoting self-harm

Although there is potential for development of a school-based intervention, care is required as it may be difficult to raise awareness without seeming to promote self-harming behaviours. A balance would be required to de-stigmatise self-harm, while promoting

young people's awareness about the issue. This may be particularly difficult given the role of social modelling identified in self injurious behaviour.

9.6. Future research

The prevalence of self-harm illustrates that it is a public health concern worthy of further research. This study shows that it is feasible to conduct qualitative and quantitative research with young people about self-harm if consideration is given to potential risk and appropriate care taken to ensure the safety of the participants. Further research could employ similar methodology, incorporating population and individual level data to contextualise self-injury.

Barriers for working with vulnerable groups, including young people are justified in terms of child protection, however, this research illustrates that there are issues which deserve further research attention. If barriers to conducting research on sensitive topics such as self-harm prevent knowledge about this maladaptive behaviour being obtained from community samples, responses to self-harm can only be informed by information gathered from different populations, such as adults who self-harm or adolescents engaged with services.

This study does not provide any clear answers to how thoughts of self-harm lead to actual self-harm, given different responses to similar stressors. This is a difficult area for further exploration, as noted by other researchers (Madge et al. 2008). Future research on triggers could include different aspects of mental health, perceived reasoning for repetition and cessation of self-harm.

The gender difference in self-harm warrants further research. There were different associations evident for males and females which were unable to be explored further in this analysis due to lack of power. For example previous depressive symptoms predicted self-harm in boys only, and low social support from friends predicted self-harm in girls, but not boys. Future community-based studies could over-sample boys to increase statistical power to explore this. There are implications for service provision and use, as the substantially higher prevalence in females may influence the services available for young males.

Future research with a larger sample may facilitate stratified analyses to examine variation of self-harm within ethnic groups. The cultural or religious nuances implicit in qualitative accounts of self-harm have potential to inform school and service-based responses to young people from those minority ethnic groups who self-harm. Similarly, gaining an appreciation of input from support networks and services, providing insight into the way that young people behave, and what has potential to influence their behaviour.

As self-harm may function as an experimental adolescent behaviour, future research could address health risk behaviours in relation to self-harm. That is, exploration of whether some young people view self-harm as an experimental behaviour to try out, as they would experiment with smoking or alcohol or drugs.

Although suicidal ideation was not examined in depth in this study, the qualitative accounts facilitated some exploration of suicidal ideation in relation to self-injurious behaviours. This issue requires further qualitative research, as quantitative methods can assess self-injury, and suicidal ideation, but may not be able to explore how intentions relate to actions, or whether expression of suicidal ideation could simply be a turn of phrase (Scoliers et al. 2008).

Future research could employ the use of different qualitative methodology, with potential to conduct fewer more in-depth interviews. Research could also potentially employ a more theoretical stance. For example, if an IPA approach were adopted (Smith & Osborn 2003), the study may be conducted couching self-harm within psychological theory relating to identity, or cognitive processes within the interpretation of the young people's experiences. Both positive and negative views about services imply that at some stage during service use, young people's attitudes may change. Future research could explore what influences such attitudinal changes, and whether any attitudinal barriers could be addressed at a community level to encourage engagement with services, should they be required.

Further research is justified to inform development of interventions to be used with young people about emotional health and well-being. This could explore barriers to help-seeking, gaining input from young people about how to facilitate access to appropriate services. Descriptions and perceptions during the process of service use and the role played by the young person's wishes would be informative to study, should such research be deemed ethical. This study has provided some insight into lay beliefs about self-harm. Lay beliefs

about what might be beneficial for someone who self-harms might be worth exploring, with the intention of informing a community-based psychoeducation intervention.

Qualitative research could address teachers' attitudes to and experiences of young people who self-harm, and also the relationships between school staff and health service provision. Such views would be valuable to inform potential training for those working in schools.

Finally, given that people who self-harm may be vulnerable, further research is required into the implications of conducting research with young people. Future research may be able to use repeated qualitative methods to ascertain the impact of the research, and whether or not participation functioned to trigger a different chain of events in their lives.

9.7. Conclusion

This thesis presents a detailed exploration of self-harm in adolescents in an ethnically diverse London setting. A mixed method design was employed, and the two studies conducted to examine this phenomenon both yielded unique information, addressing the aims of this research and making a valuable contribution to this field of research.

Self-harm is a complex phenomena, experienced and interpreted in a wide variety of ways. The prevalence of self-harm in this study was similar to other community-based adolescent studies, and illustrates that it is a serious public health issue. Known risk factors such as depressive symptoms and conduct problems were shown in this sample to have strong associations with self-harm.

There was some evidence for an increased risk of self-harm in Asian British adolescents, with a possible explanation from the qualitative accounts which referred to perceived restrictions on behaviour. Culture may exacerbate other stressors, rather than functioning as a central stressor itself. There was no evidence that self-harm was more acceptable in any ethnic or cultural groups.

The qualitative study illustrated many reasons why self-harm may be challenging to talk about, including different definitions, attitudes and acceptance of self-harm in oneself and others. This work highlights a need to increase understanding about self-harm and how to respond to self-harm in young people as it is a common behaviour which is challenging to comprehend.

The descriptive account of self-harm, reporting the views and experiences of adolescents could be used to inform those working with young people about the issue. Findings highlight the need for services to be made accessible to young people living in East London, and to encompass help for the psychological and social factors associated with self-harm.

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Appendices

Appendix 1: RELACHS Phase 3 questionnaire

Your answers are CONFIDENTIAL – nobody other than the research team will know what your answers are.

They will NOT be seen by your parents/carers or teachers.

Your views are important to us.

Enjoy!

Some questions about you

REMEMBER YOUR ANSWERS WILL BE KEPT CONFIDENTIAL

1. Are you a **male or a female**?

Male ☐1

Female ☐2

2. What is your **date of birth**?

_____/_____/_____
date month year

3. What **religious group** or church do you belong to? ***✓ ONE box only***

☐1 None ☐2 Jewish

☐3 Christian ☐4 Muslim/Islam

☐5 Church of England ☐6 Hindu

☐7 Methodist ☐8 Sikh

☐9 Baptist ☐10 Agnostic/Atheist

☐11 Catholic ☐12 Don't know

☐13 Other (please write in)_____

4. How often, **outside of school**, do you go to a church or synagogue or temple or mosque or for religious classes? ***✓ ONE box only***

☐1 Never

☐2 Less than once a year

☐3 About once or twice a year

☐4 About 3 or 4 times a year

☐5 About once a month

☐6 Once a week

☐7 More than once a week

5. Do you **believe** you can be **helped by prayer**?

✓ ONE box only

☐1 Very strongly

☐2 To some extent

☐3 Not at all

6. **How long** have you **lived in this country**?

☐1 All of my life

☐2 Over 10 years

☐3 6-10 years

☐4 1-5 years

☐5 less than 1 year

7. **Which country** were **you born in**?

I was born in:_____ 

8. Did **you and your family** come to this country as **refugees**?

✓ ONE box only

☐1 Yes ☐2 No ☐3 Don't Know

9. Which **category** best describes **you**? **This is your race** or ethnic group

✓ ONE box only

White	White: UK	☐1
	White: Irish	☐2
	White: Greek	☐3
	White: Turkish	☐4
	White: Orthodox Jewish	☐5
	White: Kurdish	☐6
	White: other (please write) _____	7
Mixed	Mixed: White and Black Caribbean	☐ 8
	Mixed: White and Black African	☐9
	Mixed: White and Asian	☐10
	Mixed: other (please write) _____	11
Asian	Asian: Indian	☐12
	Asian: Pakistani	☐13
	Asian: Bangladeshi	☐14
	Asian: British	☐15
	Asian: other (please write) _____	16
Black	Black: Caribbean	☐17
	Black: African	☐18
	Black: Somali	☐19
	Black: British	☐20
	Black: other (please write)_____	21
Other ethnic group		
	Chinese	☐22
	Vietnamese	☐23
	Other (please write) _____	24

Your health

10. **In general** would you **say your health is…**

*✓ **ONE box only***

☐1 very good ☐2 good ☐3 fair ☐4 bad ☐5 very bad

11. Do you have any of these **health problems?** *✓ **ALL that you have***

Asthma	☐1
Eczema	☐2
Epilepsy	☐3
Diabetes	☐4
Toothache (dental pain)	☐5

Other health problem/s (please write)

_____6

12. **Do** any of these **people in your family** have **diabetes?**

*✓ **ALL that apply***

☐1 Mum/Dad

☐2 Sister/Brother

☐3 Aunt/Uncle

☐4 Grandparent

☐5 None of these people have diabetes

This question is for females only. If you are male, → go to Question 14

13. Have you **started your periods** (menstruation) yet?

☐1 Yes ☐2 No → Go to question 14

13.1 If yes, **how old were you** when you had your **first period?** _____

write your age on the line

14. When did you last visit your…	In the last month	In the last 6 months	In the last year	Longer ago, but within the last 2 years	Longer than 2 years ago	Never Been
Dentist	☐1	☐2	☐3	☐4	☐5	☐6
Doctor (GP)	☐1	☐2	☐3	☐4	☐5	☐6

PLEASE CHECK: Have you ticked one box on EACH LINE???

15. How often do you usually brush your teeth?

✓ ONE box only

☐1 More than 3 times a day

☐2 3 times a day

☐3 Twice a day

☐4 Once a day

☐5 Less than once a day

Your home and family

These questions are about the home where you live now.

If you live in different homes, answer for the home where you live most of the time.

write the NUMBER on the line below

16. I live with _____ other adults and children NOT including myself.

(e.g. If you live with Mum, Step-dad and two sisters write '4')

17. Which adults do you **live with most of the time**?

Tick a box for each adult **who lives in your home now.**

*** ✓ ONE box on each row ***

	Yes	No
Mum	☐1	☐2
Dad	☐1	☐2
Step-dad/Mum's boyfriend/partner	☐1	☐2
Step-mum/Dad's girlfriend/partner	☐1	☐2
In Care	☐1	☐2

Other _____

write the relationship to that person on the line

18. Does your **mum** or **step-mum who you live with** have a job?

✓ ONE box only

☐1 **Mum** or Step-mum **has a job**/ is a student

☐2 **Mum** or Step-mum **does NOT** have a **job**

☐3 Don't live with mum or step-mum, or my mum has died

19. Does your **dad** or **step-dad** who you live with have a job?

✓ ONE box only

☐1 **Dad** or Step-dad **has a job**/ is a student

☐2 **Dad** or Step-dad **does NOT** have a **job**

☐3 Don't live with dad or step-dad, or my dad has died

20. How **MANY rooms** other than the kitchen, bathroom and hall **does your home have**?

write the NUMBER on the line below

My home has _____ rooms **NOT including the kitchen, bathroom and hall.**

21. Does anyone you live with **have** a **car or van**?

☐1 No ☐2 Yes, one ☐3 Yes, two or more

22. Do your parents / carers **own** or **rent your home** (if they have a mortgage, tick they own it)?

☐1 They own it ☐2 They rent it ☐3 Don't Know

23. Does your family have **access** to the **internet at home**?

☐1 No ☐2 Yes ☐3 Don't Know

24. What is your **postcode?**
(We are collecting this information to see what your local area is like)

☐1 My postcode is_____
Full Postcode (e.g. E14 8BS):

☐2 I don't know my postcode

Your moods and feelings

25. For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of **how things have been for you over the last six months**.

	Not True	Somewhat True	Certainly True
1. I try to be nice to other people, I care about their feelings	☐1	☐2	☐3
2. I am restless, I cannot stay still for long	☐1	☐2	☐3
3. I get a lot of headaches, stomach-aches or sickness	☐1	☐2	☐3
4. I usually share with others (food, games, pens etc)	☐1	☐2	☐3
5. I get very angry and often lose my temper	☐1	☐2	☐3
6. I am usually on my own, I generally play alone or keep to myself	☐1	☐2	☐3
7. I usually do as I am told	☐1	☐2	☐3
8. I worry a lot	☐1	☐2	☐3

PLEASE CHECK: Have you ticked one box on <u>EVERY</u> LINE???

	Not True	Somewhat True	Certainly True
9. I am helpful if someone is hurt, upset or feeling ill	☐1	☐2	☐3
10. I am constantly fidgeting or squirming	☐1	☐2	☐3
11. I have at least one good friend	☐1	☐2	☐3
12. I fight a lot. I can make other people do what I want	☐1	☐2	☐3
13. I am often unhappy, downhearted or tearful	☐1	☐2	☐3
14. Other people my age generally like me	☐1	☐2	☐3
15. I am easily distracted, I find it difficult to concentrate	☐1	☐2	☐3
16. I am nervous in new situations. I easily lose confidence	☐1	☐2	☐3
17. I am kind to younger children	☐1	☐2	☐3

PLEASE CHECK: Have you ticked one box on EVERY LINE???

	Not True	Somewhat True	Certainly True
18. I am often accused of lying or cheating	☐1	☐2	☐3
19. Other children or young people pick on me or bully me	☐1	☐2	☐3
20. I often volunteer to help others (parents, teachers, children)	☐1	☐2	☐3
21. I think before I do things	☐1	☐2	☐3
22. I take things that are not mine from home, school or elsewhere	☐1	☐2	☐3
23. I get on better with adults than with people my own age	☐1	☐2	☐3
24. I have many fears, I am easily scared	☐1	☐2	☐3
25. I finish the work I'm doing. My attention is good.	☐1	☐2	☐3

PLEASE CHECK: Have you ticked one box on EVERY LINE???

Some questions about school

26. Have you ever been **bullied at school**? (This could be at any school)

No ☐1 → Go to question 27

Yes ☐2 → Go to question 26.1

26.1 **How often** have you been **bullied in school this term**? (This could be at any school)

I haven't been bullied in school this term	☐1
Once or twice	☐2
Sometimes	☐3
About once a week	☐4
Several times a week	☐5

27. **How often this term** has someone done any of these things to you?

✓ ONE box on EACH LINE

	Not this term	Once or twice	Sometimes	About once a week	More than once a week
Made fun of you because of your religion or race	☐1	☐2	☐3	☐4	☐5
Made fun of you because of your looks or the way you talk	☐1	☐2	☐3	☐4	☐5
Hit, slapped or pushed you	☐1	☐2	☐3	☐4	☐5
Spread rumours or mean lies about you	☐1	☐2	☐3	☐4	☐5

Life and home

28. Please **tick one box for** each **statement about your parents / carers.**

✓ ONE box on EVERY LINE

	Always	Often	Sometimes	Rarely	Never
If I have a problem at school my parents/carers are ready to help	☐1	☐2	☐3	☐4	☐5
My parents/carers encourage me to do well at school	☐1	☐2	☐3	☐4	☐5
My parents are willing to come to school to talk to teachers	☐1	☐2	☐3	☐4	☐5

29. The next few questions are about your **mum, or the woman who cares for you** while you have been **growing up**.

If you do not have a mum or female carer, please tick this box ☐ and go to Question **30**.

✓ ONE box for EVERY LINE

	A lot	Quite a lot	A little	Not at all
How much does she **understand** your problems and worries?	☐1	☐2	☐3	☐4
How much **love and affection** does she give you?	☐1	☐2	☐3	☐4
How much **time and attention** does she give you when you need it?	☐1	☐2	☐3	☐4
How **strict** are her rules for you?	☐1	☐2	☐3	☐4
How **harsh** is she when she punishes you?	☐1	☐2	☐3	☐4
How much can you **talk to her** about things that are bothering you?	☐1	☐2	☐3	☐4

30. The next few questions are about your **dad, or the man who cares for you** while you have been **growing up**.

If you do not have a dad or male carer, please tick this box ☐ and go to Question **31**.

✓ ONE box for EVERY LINE

	A lot	Quite a lot	A little	Not at all
How much does he **understand** your problems and worries?	☐1	☐2	☐3	☐4
How much **love and affection** does he give you?	☐1	☐2	☐3	☐4
How much **time and attention** does he give you when you need it?	☐1	☐2	☐3	☐4
How **strict** are his rules for you?	☐1	☐2	☐3	☐4
How **harsh** is he when he punishes you?	☐1	☐2	☐3	☐4
How much can you **talk to him** about things that are bothering you?	☐1	☐2	☐3	☐4

31. **Have any** of the following things **happened to you during your life**?

This could have happened when you were any age.

✓ ONE box on EVERY LINE

	Yes	No
Your parents often argued or fought	☐1	☐2
You were in care / foster home / children's home	☐1	☐2
Your family had continuing money problems	☐1	☐2
Your Mum, Dad, sister or brother died	☐1	☐2
Your parents were divorced or separated	☐1	☐2
Your parents/carers had a severe illness, injury or operation	☐1	☐2
Your or your family experienced a mugging, robbery or burglary	☐1	☐2
Your parents/carers drank alcohol so often that it caused family problems	☐1	☐2

Physical activities

These questions are to see **how much exercise you do**. Please read them carefully.

32. OUTSIDE SCHOOL HOURS: **How <u>often</u>** do you usually **exercise** in your free time so much that you **get out of breath or sweat**?

*✓ **ONE box only***

Every day	☐1
4-6 times a week	☐2
2-3 times a week	☐3
Once a week	☐4
Once a month	☐5
Less than once a month	☐6
Never	☐7

33. OUTSIDE SCHOOL HOURS: **How many <u>hours a week</u>** do you usually **exercise** in your free time so much that you **get out of breath or sweat**?

*✓ **ONE box only***

None	☐1
About half an hour	☐2
About 1 hour	☐3
About 2-3 hours	☐4
About 4-6 hours	☐5
7 hours or more	☐6

34. OUTSIDE SCHOOL HOURS: On **average**, **how many <u>hours a day</u>** do you usually **watch TV / videos, play video games** or **play** on the **computer**?

*✓ **ONE box only***

Not at all	☐1
Less than half an hour a day	☐2
Half an hour to 1 hour	☐3
2-3 hours	☐4
4 hours	☐5
More than 4 hours	☐6

About you

35. These questions are about **how you might have been feeling or acting recently**. For each question, please check **how much you have felt or acted this way in the <u>past two weeks</u>.**

If a sentence was true about you most of the time, tick TRUE. If it was only sometimes true, tick SOMETIMES. If a sentence was not true about you, tick NOT TRUE.

	True	Some Times	Not True
1. I felt miserable or unhappy	☐1	☐2	☐3
2. I didn't enjoy anything at all	☐1	☐2	☐3
3. I felt so tired I just sat around and did nothing	☐1	☐2	☐3
4. I was very restless	☐1	☐2	☐3
5. I felt I was no good anymore	☐1	☐2	☐3
6. I cried a lot	☐1	☐2	☐3
7. I found it hard to think properly or concentrate	☐1	☐2	☐3
8. I hated myself	☐1	☐2	☐3
9. I was a bad person	☐1	☐2	☐3
10. I felt lonely	☐1	☐2	☐3
11. I thought nobody really loved me	☐1	☐2	☐3
12. I thought I could never be as good as other kids	☐1	☐2	☐3
13. I did everything wrong	☐1	☐2	☐3

PLEASE CHECK: Have you ticked one box on <u>EVERY</u> LINE???

REMEMBER- NO ONE WHO KNOWS YOU WILL SEE YOUR ANSWERS

36. Have you ever **deliberately** taken an **overdose** (e.g. pills or other medication) or tried to **harm yourself in some other way** (such as cut yourself)?

Yes ☐2 No ☐ → **If No, → Go to question 37**

If YES, go to question **36.1**

36.1 If you have, **when was the last time** you took an overdose or tried to harm yourself? *✓ **ONE box only***

Less than a month ago ☐1

Between a month and a year ago ☐2

More than a year ago ☐3

36.2 **Describe** what you did to yourself **on that occasion**. Give as much detail as you can.

36.3 On that occasion, **why** do you think you took the overdose or tried to harm yourself?

☐1 I wanted to show how desperate I was feeling

☐2 I wanted to die

☐3 I wanted to punish myself

☐4 I wanted to frighten someone

☐5 I wanted to get my own back on someone

☐6 I wanted to get relief from a terrible state of mind

☐7 I wanted to find out if someone really loved me

☐8 I wanted to get some attention

☐9 Other_____

Smoking

REMEMBER - NOBODY YOU KNOW WILL SEE YOUR ANSWERS

37. Now read the following sentences carefully and **tick the box** next to the one which **best describes you**

I have never smoked ☐1 → Go to question 40

I have only ever tried smoking once ☐2

I used to smoke sometimes but I never smoke a cigarette now ☐3

I sometimes smoke cigarettes now, but I don't smoke as many as one a week ☐4

I usually smoke between one and six cigarettes a week ☐5

I smoke more than six cigarettes a week ☐6

→ Go to question 38

38. Just to check, read the statements below carefully and **tick the box** next to the one which **best describes you.**

I have never tried smoking a cigarette, not even a puff or two ☐1 → Go to question 40

I did once have a puff or two of a cigarette, but I never smoke now ☐2

I do sometimes smoke cigarettes ☐3

→ Go to question 39

39. Did you **smoke** any **cigarettes last week**?

Yes ☐2 → Go to question **39.1** No ☐1 → Go to question **40**

39.1 How many cigarettes did you **smoke last week**?

I smoked _____ **cigarettes**

40. Do **any** of the **people you live with smoke?**

No ☐1 Yes ☐2

41. **Do any of your close friends smoke?**

No ☐1 Yes ☐2

Cultural Identity

- At the beginning of the questionnaire you were asked you about your **race or ethnic group.**
- The following questions are about how similar or different you feel from people in your **race or ethnic group**. These questions are for **everyone**, whether or not you have lived in this country all your life.
- Try and answer all of the questions.

42. Do you have **good friends** who belong to **YOUR race or ethnic group**?

* ✓ **ONE box on EACH LINE***

	None	Some	Quite a lot	Most or all of them
When you are at school	☐1	☐2	☐3	☐4
When you are **outside of school**	☐1	☐2	☐3	☐4

43. **Do you have** good friends **who belong to** OTHER races or ethnic groups**?**

* ✓ **ONE box on EACH LINE***

	None	Some	Quite a lot	Most or all of them
When you are at school	☐1	☐2	☐3	☐4
When you are **outside of school**	☐1	☐2	☐3	☐4

44. Do you wear **clothes similar** to people from **YOUR race or ethnic group**?

*✓ **ONE box on EACH LINE***

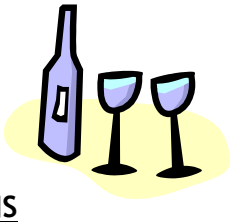
	Never	Sometimes	Often	Always
When you are outside school with friends	☐1	☐2	☐3	☐4
When you are at home with **parents/carers**	☐1	☐2	☐3	☐4

45. **Do you wear** clothes similar **to people from** OTHER races or ethnic groups**?**

*✓ **ONE box on EACH LINE***

	Never	Sometimes	Often	Always
When you are outside school with friends	☐1	☐2	☐3	☐4
When you are at home with **parents/carers**	☐1	☐2	☐3	☐4

Drinking



REMEMBER - NOBODY YOU KNOW WILL SEE THE ANSWER TO THESE QUESTIONS

46. Have you **ever** had a proper **alcoholic drink** – a whole drink, not just a sip? **Please don't count drinks labelled low alcohol.**

No ☐1 ➡ Go to question 49

Yes ☐2 ➡ Go to question 47

47. **How often** do you **usually have** an **alcoholic drink**?

✓ ONE box only

Almost every day	☐1
About twice a week	☐2
About once a week	☐3
About once a fortnight	☐4
About once a month	☐5
Only a few times a year	☐6
I never drink alcohol now	☐7

48. Did you have an **alcoholic** drink **in the last week**?

No ☐1 ➡ Go to question 49

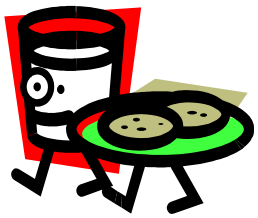
Yes ☐2 ➡ Go to question 48.1

48.1 In the **last week**, **how many** of **each** of the **drinks did you have**? Please write the **number of drinks** you had in the empty box below each type of drink.

1	2	3	4	5
				
1 can of beer/cider	½ Pint of Beer/ Cider	1 Single Spirit / Liqueur	1 Glass of Wine	1 Bottle of Alcopop

Please write the **number of drinks** you had in the empty box below each type of drink.

Eating



49. Before going to school how **often** do you **have breakfast at home or school breakfast club?** *✓ ONE box*

Every day	☐1
3 - 4 days a week	☐2
1 - 2 days a week	☐3
Never or hardly ever	☐4

50. About **how many portions** of **fruit** do you usually **eat in a day**? (One portion means a whole piece of fruit, like a banana, or a handful of smaller fruit, like grapes, or a glass of juice. Juice can only count as one portion, however much you drink.)

None	1	2	3	4	5 or more
☐	☐	☐	☐	☐	☐

51. About **how many portions** of **vegetables** do you usually **eat in a day**? Please do not include potatoes. (A portion means a handful-sized amount.)

None	1	2	3	4	5 or more
☐	☐	☐	☐	☐	☐

52. **How often** do you **eat** or **drink** the **following**?

✓ ONE box on EVERY LINE

	More than once a day	Once a day	At least once a week	Rarely	Never
Crisps or savoury snacks	☐1	☐2	☐3	☐4	☐5
Sweets, ghee sweets or Chocolate	☐1	☐2	☐3	☐4	☐5
Biscuits	☐1	☐2	☐3	☐4	☐5
Fried food, chips, Samosas or bhajis, or Fried English breakfast	☐1	☐2	☐3	☐4	☐5
Fizzy Drinks (e.g Tango)	☐1	☐2	☐3	☐4	☐5

Your neighbourhood

53. Here are **some things** that **people** sometimes **say about the area where they live. Do you agree?**

✓ ONE box for EVERY LINE

	Strongly agree	Agree	Disagree	Strongly disagree
I like this area	☐1	☐2	☐3	☐4
I feel safe in this area	☐1	☐2	☐3	☐4
I feel part of this area	☐1	☐2	☐3	☐4
I want to leave this area	☐1	☐2	☐3	☐4
I like the people in this area	☐1	☐2	☐3	☐4
Other people think this is a good area	☐1	☐2	☐3	☐4
There are lots of places for young people to meet in this area	☐1	☐2	☐3	☐4
I have friends who live in this area	☐1	☐2	☐3	☐4

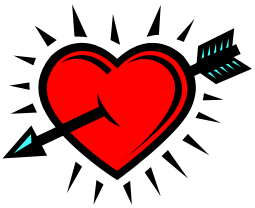
54. How often do you **use your local neighbourhood** for the following **activities**?

✓ ONE box on EACH LINE

	Never	Sometimes	Often
To avoid people	☐1	☐2	☐3
To be alone	☐1	☐2	☐3
To be free from the expectations of your friends	☐1	☐2	☐3
To be in control of the environment	☐1	☐2	☐3
To be in your own space	☐1	☐2	☐3
To be on your own to think	☐1	☐2	☐3
To be peaceful	☐1	☐2	☐3
To get away from your friends	☐1	☐2	☐3
To get away from your peers	☐1	☐2	☐3

PLEASE CHECK: Have you ticked one box on EVERY LINE???

Sex and Relationships



These questions are about young people and sexual relationships. There are no "right" or "wrong" answers. Young people do sexual things at different ages. Some people are attracted to the same sex, some to both sexes and some to the opposite sex. We are interested in your ideas and experiences whatever they are, so please answer these questions as honestly as possible.

REMEMBER- NO ONE WHO KNOWS YOU WILL EVER SEE THE ANSWERS TO THESE QUESTIONS

55. Have you experienced the following things with a boy or girl?

✓ ONE box on EVERY LINE

	Yes	No
Kissing using tongues	☐1	☐2
Heavy petting (touched each others private parts/genitals)	☐1	☐2
Oral sex (mouth touching private parts/genitals)	☐1	☐2
Sexual intercourse	☐1	☐2

If you have never had sexual intercourse, go to Question 58 on page 29.

56. When you **FIRST** had sexual intercourse, how old were you?

I was_____ years old when I first had sexual intercourse.

write the AGE on the line

57. Have you **ever** had sex **without protecting** yourself or using **any form of contraception**?

✓ ONE box only

☐1 Yes ☐2 No ☐3 Don't Know

Drugs

REMEMBER NOBODY YOU KNOW WILL SEE THE ANSWER TO THESE QUESTIONS

58. When was the last time you ever used or **took any of the following**, if ever?

✓ ONE box on EVERY LINE

		In the last month	In the last year	More than a year ago	Never
Cannabis	(Marijuana, Dope, Pot, Blow, Hash, Black, Grass, Draw, Ganja, Spliff, Joints, Smoke, Weed, Puff, Skunk, Herb)	☐2	☐3	☐4	☐5
Glue/ solvents/gas	(aerosols, lighter fluid, butane, petrol, nail varnish remover)	☐2	☐3	☐4	☐5
Ecstasy	('E', Dennis the Menace, XTC, X, MDMA, Doves, Mitsubishis, Pills, Adam, Eve, Edward)	☐2	☐3	☐4	☐5
Crack	(Rock, Stone, White)	☐2	☐3	☐4	☐5
Heroin	(Morphine, Smack, Scag, 'H', Brown, Junk, Gear)	☐2	☐3	☐4	☐5
Amphetamines	(Speed, Uppers, Whizz, Sulphate, Billy, Sulph, Base)	☐2	☐3	☐4	☐5
Deccopan	(Dex, Decco, Wax, DP, Drops)	☐2	☐3	☐4	☐5
LSD	(Acid, Tabs, Trips, Stars, Blotters, Microdots)	☐2	☐3	☐4	☐5
Cocaine	(Charlie, Snow, White, coke, C)	☐2	☐3	☐4	☐5
Khat	(Quat, Qat, Kat, Quadka, Chat)	☐2	☐3	☐4	☐5

PLEASE CHECK: Have you ticked one box on EVERY LINE???

Some more questions about school

59. In your opinion, what do your **teachers** think about your **school performance** compared with your classmates?

✓ ONE box ONLY

Very good	☐1
Good	☐2
Average	☐3
Below average	☐4

60. How do you feel about **school at the moment**?

✓ ONE box ONLY

I like it a lot	☐1
I like it a bit	☐2
I don't like it very much	☐3
I don't like it at all	☐4

61. Here are some statements about the **students** in your **classes**. Please show how much you agree or disagree with each statement.

✓ ONE box on EACH LINE

	Strongly Agree	Agree	Neither agree nor Disagree	Disagree	Strongly Disagree
The students in my classes enjoy being together	☐1	☐2	☐3	☐4	☐5
Most of the students in my classes are kind and helpful	☐1	☐2	☐3	☐4	☐5
Other students accept me as I am	☐1	☐2	☐3	☐4	☐5

62. How strongly do you agree or disagree with each of the following statements?

✓ ONE box on EACH LINE

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
I feel close to people at this school	☐1	☐2	☐3	☐4	☐5
I feel like I am part of this school	☐1	☐2	☐3	☐4	☐5
I am happy to be at this school	☐1	☐2	☐3	☐4	☐5
I feel safe in my school	☐1	☐2	☐3	☐4	☐5

63. Here are some statements about **your teachers**. Please show how much you agree or disagree with each statement.

✓ ONE box on EACH LINE

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
I am encouraged to express my own views in my classes	☐1	☐2	☐3	☐4	☐5
Our teachers treat us fairly	☐1	☐2	☐3	☐4	☐5
When I need extra help, I can get it	☐1	☐2	☐3	☐4	☐5

People around you

64. We are interested in **how you feel about the following statements.** Read each statement carefully. (**Neutral** means you do **not agree or disagree**)

✓ ONE box on EVERY LINE

	Disagree Very Strongly	Disagree Strongly	Disagree Mildly	Neutral	Agree Mildly	Agree Strongly	Agree Very Strongly
There is a special person who is around when I am in need	☐1	☐2	☐3	☐4	☐5	☐6	☐7
There is a special person with whom I can share joys and sorrows	☐1	☐2	☐3	☐4	☐5	☐6	☐7
My family really tries to help me	☐1	☐2	☐3	☐4	☐5	☐6	☐7
I get the emotional help and support I need from my family	☐1	☐2	☐3	☐4	☐5	☐6	☐7
I have a special person who is a real source of comfort to me	☐1	☐2	☐3	☐4	☐5	☐6	☐7
My friends really try to help me	☐1	☐2	☐3	☐4	☐5	☐6	☐7
I can count on my friends when things go wrong	☐1	☐2	☐3	☐4	☐5	☐6	☐7
I can talk about my problems with my family	☐1	☐2	☐3	☐4	☐5	☐6	☐7
I have friends with whom I can share my joys and sorrows	☐1	☐2	☐3	☐4	☐5	☐6	☐7
There is a special person in my life who cares about my feelings	☐1	☐2	☐3	☐4	☐5	☐6	☐7
My family is willing to help me make decisions	☐1	☐2	☐3	☐4	☐5	☐6	☐7
I can talk about my problems with my friends	☐1	☐2	☐3	☐4	☐5	☐6	☐7

65. Who is the **special person** you have answered these questions about?

☐1 Girlfriend/Boyfriend ☐2 Other friend ☐3Family member

☐4 Other_____

The Future

66. If you had a choice, what would you **like to be doing next year**?

✓ ALL boxes that apply

☐1 Doing A levels

☐2 Doing some other course at school (6th form) or at College

☐3 Getting a full-time job

☐4 Getting a part-time job

☐5 Getting an apprenticeship/ training/ employment training course

☐6 Be unemployed

☐7 Don't know

☐8 Leave school

If you have any comments you would like to make, please write them in the box below.

That's it!!!

Well Done!!

Thanks for taking part!

Now, please go back and check that you have not missed any questions….

Appendix 2: RELACHS Phase 3 teacher information

RELACHS Study. Room 3.08, MS Building, Queen Mary University of London, Mile End Road, London, E1 4NS.
Tel: 020 7882 7648 Fax: 020 7882 7924 Email: relachs@qmul.ac.uk Web: www.relachs.org

Information sheet for TEACHERS

Research with East London Adolescents: Community Health Survey – (RELACHS) 2005

We are conducting the third wave of a survey looking at risk and protective factors for health of adolescents in East London. We hope that the findings from this survey will help towards the improvement of the physical and mental well-being of adolescents. It will involve the pupils in your class completing a questionnaire and having their height and weight measured.

If parents/carers ask you what the study is about please explain using the summary below. If they have any more questions please encourage them to phone the research team, the number is 020 7882 7648.

Summary of what the study involves...

- The survey is about physical health and mental well-being. The questionnaire addresses health, health behaviours and attitudes. For example, physical activity, eating, injuries, social support, sex and relationships. Also they will be weighed and measured (with school uniform on) to gauge physical growth. We will also carry out visual inspections of their front teeth. The researchers will look at school and external data so they can find out more about the pupil's without testing them.

- The pupils will be given an explanation of the study before starting the questionnaire.

- The pupils will be asked for their written consent to participate on the day of the survey activities. Any pupil who does not wish to participate will not have to and there will be no pressure put on them to participate. If a pupil begins filling-in the questionnaire and later decides they do not want to take part, they can withdraw without having to give a reason.

- All the pupils' answers will be kept entirely confidential. Only the researchers will have access to the pupil's answers. We cannot disclose their answers to the school, Local Education Authority or any other person or group.

- There will be researchers on hand to help any pupils that are finding the questionnaire difficult and answer any questions they may have.

- The possibility of being randomly selected for optional group work exploring opinions in a small group discussion.

- The survey has received full ethical approval by the East London and the City Health Authority Research Ethics Committee.

- It is important to note that pupils find the questionnaire really interesting and it encourages them to think about important health issues.

Investigators:
Professor Stephen Stansfeld, University of London
Professor Robert Booy, University of London
Dr Russell Viner, University of London
Jenny Head, University of London
Dr Stephanie Taylor, University of London
Dr Kamaldeep Bhui, University of London
Dr Charlotte Clark, University of London
Emily Klineberg, University of London

Appendix 3: RELACHS Phase 3 pupil information

RELACHS Study. BMS Building, Queen Mary College, Mile End Road, London, E1 4NS.
Tel: 020 7882 7648 Fax: 020 7882 7924 Email: Relachs@qmul.ac.uk Web: www.relachs.org.uk

CONFIDENTIAL

Pupil Invitation

Research with East London Adolescents – Community Health Survey (RELACHS) 2005

Dear Pupil,
Do you remember that you took part in the RELACHS study in 2001 and 2003? If you do, you will know this study is based on your opinions, feelings and behaviours. We are now returning to see how your health is 2 years later. We are trying to find out about the health of 13 – 18 year olds in East London and the impact of health improvement projects in your area. 3000 other pupils like you and most of the schools in East London are taking part in this study.

The study will involve….

- Filling in a questionnaire during class time about your health, health behaviours and attitudes for example, physical activity, eating, accidents and injuries, social support, sex and relationships. It will be **completely confidential**. Your parents or teachers will not be able to see your answers and your name will not be on the questionnaire. The questionnaires will be kept in a locked cupboard and only researchers will have access to them. The researchers will look at school data so they can find out more about you without testing you.

- Measuring your height and weight in private to look at your physical growth. You will keep your school uniform on. This information will also be kept confidential. We would also like to carry out a visual inspection of your front teeth.

- You may be randomly selected for a small group discussion about your feelings, health and attitudes at a later stage.

- Taking part in this study is entirely your choice. If you decide to take part you can stop at any time without giving a reason. If you don't want to answer any question you can miss it out.

- If you are worried about any part of the study or want any more information, please ask the researchers or phone Emily Klineberg or Davina Woodley-Jones on 020 7882 7648.

We look forward to hearing your point of view.

Appendix 4: RELACHS Phase 3 parent information

Room 308, MS Building, Queen Mary University of London, Mile End Road, London, E1 4NS.
Tel: 020 7882 7648 Fax: 020 7882 7924 Email: relachs@qmul.ac.uk Web: www.relachs.org

Dear Parents / Carers,

RE: Research with East London Adolescents: Community Health Survey (RELACHS)

The Head Teacher has permitted us to look again at the health of adolescents in your child's school. Some of you may remember your child taking part in the RELACHS study in 2001 and 2003, a study looking at risk and protective factors for health. The study will involve your child filling out a questionnaire in a classroom with their classmates during class time. This is an East End initiative, involving 3000 adolescents and most of the secondary schools in East London.

The purpose of our study is to…

- Collect health and lifestyle information, such as eating, physical activity, social support, sex and relationships, self-esteem, on adolescents in East London schools.
- Look at the effects of regeneration initiatives on the health of East London adolescents.
- Our findings are potentially very important in identifying the needs of adolescents in East London, and therefore tailoring service provision to benefit your community.

What participation will involve for your child…

- An explanation of the study.
- Signing a form to consent to participate. They can opt out at any stage if they choose.
- Filling in a questionnaire about their health, health behaviours and attitudes for example, physical activity, eating, accidents and injuries, social support, sex and relationships.
- Being weighed and measured (with school uniform on) to gauge physical growth, and having a dentist carry out a visual inspection of their teeth.
- The possibility of being randomly selected for small group discussions.
- There is also a possibility that we may contact your child in a few years to follow up his/her health.

Further information…

- The researchers will look at external and school data so they can find out more about your child without testing them, for example, key stage 2 results.
- All of the information collected will be kept **strictly confidential** and will **only** be viewed by the research team. No names will be attached to any of the information.
- Pupils enjoyed taking part in previous phases of the study, and it has encouraged them to think more about health issues. We have sent a summary of our findings at each stage back to the participants.

What this means for parents…

- You are free to choose whether your child participates in the study.
- If you do **NOT** want your child to take part please sign the form on the other side of this page and return it to school **in the next two days**.

Please don't hesitate to contact us on 020 7882 7648 or relachs@qmul.ac.uk if you have any queries about the study. You can also visit our website for more information: www.relachs.org. Thank you very much.

Yours sincerely,
Professor Stephen Stansfeld, Dr Charlotte Clark, Emily Klineberg and Davina Woodley-Jones
On behalf of the RELACHS team

Appendix 5: RELACHS Phase 3 pupil consent inner page

CONFIDENTIAL

Research with East London Adolescents – Community Health Survey

Pupil's consent form

- I have listened to the explanation about the Research with East London Adolescents – Community Health Survey.

3. All my questions about the study have been answered and I know what is being asked of me, and how long it will take.

4. I know that I can stop taking part in the study at any time and I don't have to answer any question I don't want to.

- I know that I don't have to have my height and weight measured or teeth checked if I don't want to.

- I freely consent to take part in the study. No-one h put pressure on me.

1. I will give honest and accurate answers knowing full well that they will be kept confidential.

- I agree to fill out a confidential questionnaire about myself and my health.

- I agree to have my height and weight measured.

- I agree that a dentist will have a quick look in my mouth with a mirror.

- I know that if there are any problems, I can contact:

Emily Klineberg, Davina Woodley-Jones or Professor Ste Stansfeld on 020 7882 7648

5. I agree to take part in the study (Please sign)

_____

6. (Signature)

Code: _____

Height: _____

M code ?

RELACHS

INVITES YOU

To take part in our study!

Appendix 6: Qualitative study & pilot protocol

School Protocol

This document contains an overall protocol for all aspects of school liaison and data collection at school.

Contents

Approach to School & Head Teacher consent

- Contact with the RELACHS 3 liaison teacher: The RELACHS 3 liaison teacher will be contacted by phone for a brief discussion of the feasibility of conducting the sub-study within their school. This discussion will include the logistics of working with year 11s, being given the class lists to allocate codes to the pupils prior to the screening questionnaire, how to minimize the burden on the school, and an offer of 'giving something back' to the school in return for their assistance and participation. The teacher will be given the 'Information for Teachers', as preliminary information, and will be asked to advise which of the Head or Deputy Head teacher would be most appropriate to contact for full school consent.

- If the contact teacher is no longer at the school, the approach will be made directly to the head teacher.

- The researcher will visit the Head Teacher to briefly explain the study and seek consent for visiting the school. The head teacher will be given the 'Information for Teachers' and 'Signed Consent' letters in this visit.

- Only schools who had previously participated in RELACHS will be approached.

- If the head teacher does not with for his/her school to take part, the next school will be approached.

- Schools will be approached in a staggered order, allowing time for screening and interviews at previous schools to be conducted.

- With the assistance of the Liaison teacher, times and dates for the screening questionnaire will be arranged as soon as head teacher consent is given. Liaison with this teacher will be primarily by phone and fax.

- Check to see whether the Head Teacher or Liaison teacher thinks it appropriate to inform the school counsellor about the research, and contact the counsellor appropriately, informing him / her about the nature of the study, and also the dates of questionnaire screening, and later interviews when they are arranged.

- The researcher will endeavor to contact the main support staff in the school, including the Attendance Welfare Officer (AWO), the link Educational Psychologist and the designated teacher for Child Protection. Depending on the staffing at each school the main contact may vary, but at least one of these support staff will be given a full briefing about the study. However, it will be emphasized that both young people who have and have not self-harmed will be interviewed, and the aim of the study is not to draw attention to those who report self-harm. Any further support will need to be handled sensitively, and on a case-by-case basis. The study advisory panel will also be approached for advice on appropriate actions if a young person in thought to be at serious risk.

- The researcher will make a list of contact people and numbers for each school, including the range of support staff, should their names and contact details be required for any participant. In identifying the roles each of these people at the school, this will allow the researcher to know who to contact at each school to be briefed fully about the study, and if there are serious concerns about the young person.

- When giving the appropriate teacher a full briefing about the study, the liaison with Children's Services and the Study Advisory Panel are to be mentioned as reassurance of the awareness of duty of care to both the young people potentially participating in the study, and to the school.

- The first school will function as a pilot for both the screening questionnaires and the interviews. Focus groups will be held following the screening questionnaire, and an informal discussion will follow the interview for development of in-school protocol and materials.

Class lists and code generation

- The liaison teacher will be asked to provide the names of all pupils in year 11 prior to the screening questionnaire. This will allow the questionnaire to be labeled with codes prior to the school visit.

- Each code will take the form:

  RELACHS school number → 02 | 123 ← number, starting with 001 for each school

- Pupils will be numbered starting with 001 in each school according to the order on the class list.

- If a pupil is in the class who was not on the class list, they will be assigned a code with the school number, followed by 'new1', 'new2' and so on.

- Code stickers will be prepared prior to the screening questionnaire session. The information letters and opt out forms will NOT be coded, but the consent forms and screening questionnaires will be coded, and stored separately. Consent forms will require both names and codes.

Parent letters and pupil letter distribution

- One week prior to the screening questionnaire, letters for each pupil in the year and his/her parents will be taken to the school, for distribution to pupils.

- Parents wishing to opt their child out are requested to return the opt out form to the school. The liaison teacher will be asked to collect the forms to return to the researcher on the day of testing, and will be given a folder in which to collect the returned forms.

Screening:

General guidelines for research in schools

- Follow the same verbal instructions in each of the schools, trying as much as possible not to give more encouragement to one class/participant over another.
- Even though the questionnaires are to be administered in the classroom, they will be completed individually under exam conditions.
- Try not to touch the pupils while in the classroom unless in the case of a first aid emergency (adjusting pupil's head angle may be necessary for the H&W measures).
- Identify pupils by their names if possible
- Avoid using derogatory language or teasing a child
- Be nice / approachable to the class – you are not there in the capacity of teachers or parents
- Be polite and friendly
- Get to school on time
- Appear organised and professional. It is important that we make a good impression on schools
- Do not touch any school equipment
- Dress appropriately i.e. smart casual
- Do not talk about other schools, the area, the pupils (unless necessary for the study)

- If there is any trouble getting to school e.g. sickness, transport, etc phone the liaison teacher to inform him/her
- Ensure your mobiles are switched on in the morning and off during the testing session
- If asked about the class behaviour/ performance always try to give a positive impression
- If asked by the school about feedback/results from the research, offer to supply the school with an overall findings review at the end of the study. We will not be giving feedback about individual pupils or at school level, only for the whole study.
- If a pupil is distressed, or asks to speak with the researcher after the screening questionnaire session, stop packing up and find an appropriate place to sit down with the student to enquire how they are or what they would like to talk about. Although the researcher is likely to have a background in psychology (Emily Klineberg does, but there may be other people assisting with data collection who do not), it is not the role of the researcher to act as a counsellor for the participant. The researcher should listen to the participant and, where appropriate encourage him / her to approach the school counsellor or GP for more formal help, should it be required.
- There is a 'consultation panel' established for the sub-study interviews, should the researcher wish to seek advice about the best way to assist the young person to seek the help that he or she may require. This panel includes Named Doctors for Safeguarding Children in both Newham and Tower Hamlets. This panel could also be consulted following the screening questionnaire, if the researcher was particularly concerned.

Materials

- Checklist for each school visit:
    - Directions for school and details of visit time
    - School phone number and liaions person contact details
    - Class lists with codes
    - Coded consent forms and questionnaires for all potential participants
    - Spare questionnaires and consent forms
    - Verbal instructions
    - RELACHS pens (as spare pens only)
    - Folder to collect consent forms
    - Folder to collect screening questionnaires
    - Log book
    - Participation code sheet
    - Queen Mary ID badge
    - Thank you and further information leaflets for all participants / know who has leaflets / service information access for the school, where possible.

School visit

- Upon arrival at school, sign in and ask for the Liaison Teacher to be informed that you have arrived.
- Check that parent opt out forms have been distributed and check if any have been returned.
- If the information sheets have not been distributed, the session will not be able to continue as participants have not had sufficient time to consider their consent, and their parents have not been informed.
- Ask the teacher how they envisage the session to work i.e. will I have half the class at a time, or the whole class, and whether there can be arrangements for the half of the class not participating, including those who have been opted out, or do not consent to participate.
- Request permission to arrange the furniture to facilitate individual work / exam conditions.
- Request that the teacher does not assist with answering the questionnaires, but helps with discipline when required.
- Ask the teacher if any pupils are likely to need assistance in asnwering the questions. Try to avoid the situation where one pupil is translating for another, as the information is highly confidential, and the screening questionnaire will function to select the interview sample for interviews to be conducted in English.
- Note whether any pupil needs assistance (using assistance codes), as this may influence whether the pupil is eligible for interview selection.
- If the school wishes the school counsellor to be involved, ensure that the counsellor is aware of the visit and the content of the screening questionnaire.
- At the end of the session the pupils will be told that if there is anything they are worried about or want to talk about, they can speak to a research psychologist in private/confidence. They are also reminded that all information they have provided will remain strictly confidential.
- When pupils have completed their questionniare, remind them to have a quick check for their answers to ensure they haven't left anything out, and ask them to return the questionniare and consent form to the separate folders before returning to class.
- The school counsellor will be informed that the study is being conducted, and the researcher will ensure that the participants are also aware that they have a school counsellor, should they require further support. The school counsellor will also have access to information about specific services for young people in the area.

- *Thank the teacher!* And remember to collect all materials to take back to QM.

Sub-study verbal instructions & consent: Screening questionnaire

(May be said to the whole class, prior to splitting into small groups for questionnaire administration, or may be said directly to the small groups)

Good morning/afternoon year 11. My name is Emily Klineberg, and I'm doing a PhD at Queen Mary College, and today I'm here to ask for your help with my research. Did you all receive a letter about my study a week or so ago?

My project is linked to a big study called RELACHS – Research with East London Adolescents; Community Health Survey – which has been going on in schools in Newham, Tower Hamlets & Hackney since 2001. We have surveyed thousands of people just like you, and visited this school quite a few times over the years.

Today I'm going to ask you to fill in a very quick questionnaire about yourself. In this sort of research, there are no right or wrong answers, and everything you tell us will be kept confidential. The pages where you write your answers has a code on it, not your name – so nobody other than the researchers will know that they are your answers. Your parents/ carers or teachers or anyone you know won't see what you write – only the researchers will see them, and we promise to keep what you say confidential.
Do you have any questions?

Before you do the questionnaire, I need to you to have a look at the folded page on the front – it's and invitation to take part. The invitation has 4 boxes on it for you to sign, to show that you understand and agree with what we are asking you to do. – which is to fill out a confidential questionnaire for about 10-15 minutes. If you read through that folded page, and agree to take part, please initial the 4 boxes and sign it at the end. As you can see, I need to sign the form too, so I will be coming around to each one of you to check that you are happy to participate today and have filled out the consent form properly. Once you have filled it out - THEN you can start the questionnaire. If you have any questions, please don't hesitate to ask. You don't have to answer any question you don't want to, and can stop taking part at any time. BUT I do ask you to answer as many questions as you feel comfortable answering.

This is an initial questionnaire, and I'm planning to invite a few people to have a chat with me at a later date – and that chat will be confidential too. I'm not sure who will be invited to that, or even when it will be at this stage, but I'll be sorting that out after you complete the questionnaires today. So I may be in touch with you later on.

If you have any questions, or there are words in the questionnaire that you aren't sure what they mean, please put up your hand and ask.

If the pupil refuses to sign the consent form*, inform them that their answers will not be used in the study. And if they have filled out the questionnaire, they are implicitly giving their consent anyway, so it's just to make really sure that they agree that they have to sign the form.*

At the end:
Thank you for filling that in – I'm going to take these back to the university – and we keep the consent forms and the answers in separate places for confidentiality. There are some information sheets for you about services in your local area for young people… and thanks very much for taking part.
If you can put your completed questionnaires in this box and the signed consent forms in this box, that would be great.

If you have any further questions about the study, or wanted to have a chat after you have completed your questionnaire, I'll be around until *xx time*, or you can contact me on the number or email on the information sheet I gave you. You could also discuss any issues with the school counsellor.

In-school Participation Codes *(to be written on class lists)*

1. Participated
2. Absent (sick)
3. Absent (holiday)
4. Absent (no reason)
5. Did not receive letter
6. Parent opted out
7. Child opted out
8. Other
9. No longer on register (left school or class since class list given to researcher)
10. Absent (excluded from school)
11. Absent (other activity)
12. Absent (educated offsite e.g. Pupil Referral Unit)

Assistance codes **(to be written on the front of individual questionnaires & the class list, based on leader assessment)**

A0 Pupil was given an alternative task, being excluded for language or learning reasons

A1 Pupil was given assistance, and could not have completed the questionnaire without consistent help from a member of the RELACHS team.

A2 Pupil was given a fair amount of assistance from a member of the RELACHS team. i.e. pupil had a few questions read out to him/her or required explanations for more than half of the questionnaire.

A3 Pupil was given assistance by a classroom assistant.

Answers for frequently asked questions

- ***If asked what it is all about?*** Keep answer quite general: coping, risk taking and stress. This study is looking at health and well-being. Things like coping and support and how you feel about things… resilience and how young people cope with different things in different ways.

- ***If asked what is meant by self-harm?*** Reflect the question back to the participant, as we are endeavouring to explore what they mean by self-harm. For the purposes of the study, it will refer to any self-inflicted, injury or harm that is non-fatal. If participants name a specific behaviour and ask whether or not it is self-harm while completing the questionnaire, the definitions of self-harm from the Lifestyle and Coping Skills Survey will be used as a guide.

- ***If asked how the people who will be interviewed are chosen.*** Keep answer quite general, saying it will involve some of the things written in the questionnaire and some people will be randomly chosen.

- ***If asked by interview participant if the other people being interviewed have also self-harmed, and will be asked about self-harm.*** As above, it is a combination of responses in the questionnaire and also some random selection. Explain that the aim of the study is to look at stress and ways that people cope with it, and the questions will be tailored to the answers that different people give, so some questions will be the same and others will be different.

- ***If asked what is meant by 'serious risk' in the interview invitation and verbal instructions.*** This relates to a participant disclosing serious suicidal ideation or making reference to circumstances in their life which threaten their health and well-being, or that of those around them.

- ***Confidentiality:*** assure the participants that nobody who knows them will see their answers. Explain that when we enter their answers into a database, there will be up to 1000 other people who have also answered the questions, and only their codes will be used. If they ask why their name was on their consent form, explain that it ensures that we ask the right people i.e. the people who have done RELACHS studies before, but we will only identify / analyse their answers using their code.

- If a young person discloses that they are at serious risk, see Protocol for Child Protection and Risk. In the interview information letter, it is stated that if they are at serious risk, the researcher will need to consult their advisers, and this will be done privately. If the researcher feels that the participant is at significant risk, this will be told to the participant at the time, informing them that the researcher will need to inform others of that risk.

- If they do not wish to participate, or answer a question, agree that we can't force them to answer anything they don't want to, but we are asking for their help to do this research. Explain that if they tell us what is going on, this will help inform to the people who decide about services for young people in their area, and so try to improve things for young people. Assure them we want to listen to what they have to say (and encourge them to write THEIR thoughts and feelings down!)

- If participants in the classroom are talking, here are some suggestions to quieten them down:
    - stand in between the people talking
    - ask the person speaking if he/she is OK to work on his/her own
    - ask if they have any questions
    - ask if they need any help
    - make sure that you return to them if they are talking again

Entry of screening questionnaire data

- All codes will be entered into and SPSS file as soon as possible after the screening session.
- Names and codes will be kept separate in all documentation except for the class lists and consent forms.
- The variables to be used in initial screening will be:
    - Gender
    - Self-harming status:
        1=no reported self-harm
        2=OD/other harm reported only once
        3=OD/other harm reported more than once
    - Ethnicity (to check that the sample is sufficiently diverse)
    - Assistance code (if applicable)

Storage of screening questionnaire data

- Screening questionnaire data will be stored in locked filing cabinets for 2 years.
- The data will be entered onto electronic databases. There will be one file linking names and codes for the purpose of follow-ing up the sample to be interviewed. Emily Klineberg will be the only researcher with access to this file.
- All other data will be identified only by code.
-

Interview sample selection

- All participants reporting self-harm will be invited for an interview.
- The non-self-harm sample will be selected at the same time as the self-harm sample to avoid drawing attention to the self-harm status of those invited for interview, and to inform the schools of the total number of required interviews at one time. Therefore the non-self-harming sample will also be loosely matched by school, however, not within class as in the 2005 pilot. As there are 2 groups of people who have self-harmed (once and more than once), 1 person who has not self-harmed will be invited for every 2 invitations sent to people who have self-harmed. If only one person has self-harmed in a given school, one person who hasn't self-harmed will be invited as well. RELACHS 3 results imply this is an unlikely situation.
- The non-self-harm sample will be 'matched' on gender, as previous research (& RELACHS 3) indicates that more females self-harm compared with males, so the majority of interviews will be with females.
- If a male reports self-harming, a non-self-harming male will also be invited, but otherwise only females will be in the non-self-harm sample.
- e.g. Within gender, if the following pattern of self-harm is reported:

People who have self-harmed	**People who have not self-harmed**
▪ 1 person has self-harmed once	▪ 1 person invited
▪ 1 person has self-harmed >once	▪ 1 person invited
▪ 2 people report self-harm (any)	▪ 1 person invited
▪ 3 people report self-harm (any)	▪ 1 person invited
▪ 4 people report self-harm (any)	▪ 2 people invited
▪ 5 people report self-harm (any)	▪ 2 people invited
▪ 6 people report self-harm (any)	▪ 3 people invited

- The above table would apply if only females reported self-harm. If a male reports self-harm, then the same criteria would apply within male participants.
- The selection of the people who have not self-harmed will be as follows; all pupils will have a number from their class list (001 – 999). A starting point will be selected using a random number table. If that person is not of the appropriate harming status and gender, then the next person on the list will be invited. The researcher will continue down the list until an appropriate person is found.
- As there are inclusion / exclusion criteria for this selection, it is standardised/ structured, but not random sampling of people who have not self-harmed. There will be no attempt to 'match' specific participants for analysis, only comparing responses at a group level.

Interviews:

Invitation to participate

- Once the numbers of pupils self-harming in each school are established, the liaison teacher will be contacted to request timeslots for interviews. It will be noted that it would be prefereable for the interviews to be an hour long and conducted at the end of the day, or just prior to a lunch break.
- The liaison teacher will also be asked to assist with finding some small space in the school for the interviews to be conducted.
- The timing for the interviews will be established before the young person is invited, so that the invitation has a specific time and date allocated to that person for their interview. The pupil will be given the opportunity to re-arrange the interview (with consent of the liaison teacher).
- Pupils will be given their invitation & information about the interview via the school one week prior to the interview. If the pupil does not wish to participate, he/she is requested to inform the relevant teacher or to contact the research team. Pupils wishing not to participate will be offered the chance to speak with the researcher to clarify any unresolved issues, will be offered another time for an interview, but will not be approached and invited again.
- The parent information letter (and opt-out form) will be distributed once again with the Pupil Interview Invitation.
- Inform the school counsellors of the timing of interviews, if the liaison teacher would like the school counsellor to be involved.

Materials

- Checklist for each school visit:
    - Directions for school and details of visit time
    - School phone number and liaison person contact details, school support staff details
    - Individual names of interview participants with codes
    - Coded consent forms for all potential participants
    - Spare consent forms
    - Folder to collect consent forms
    - Verbal instructions
    - Topic guide
    - Knowledge of self-harm status of individual to be interviewed (coded 1,2 or 3)
    - The screening questionnaire completed by the participant who will be interviewed.
    - Dictaphone and spare tapes
    - RELACHS pens for consent forms
    - Log book
    - Participation code sheet
    - Queen Mary ID badge
    - Further information leaflets for all participants / know who has leaflets / service information access for the school.

School visit

- Upon arrival at school, sign in and ask for the Liaison Teacher to be informed that you have arrived.
- Check that pupil invitation & information sheets have been distributed and check if any have been returned, or if any pupils have opted out.
- Ask the teacher how they envisage the session to work i.e. will the pupils who are being interviewed be told about the session, or will the researchers need to find them in their current classroom. Will the pupils need to be ushered across the school grounds, or will they be allowed to move to and from the interview on their own.
- If the school wishes the school counsellor to be involved, ensure that the counsellor is aware of the visit and the content of the screening questionnaire.

- *Thank the teacher!*

- Inform the teacher that, depending on the answers given in the questionnaires, the researchers will be in touch to arrange the individual interviews.

- Remember to collect all materials to take back to QM.

Sub-study verbal instructions: Individual interview

Hi, thanks for coming today. My name is Emily, and if it's OK with you, I'd like to talk with you for the next hour or so.

As with the questionnaire you filled out, – only the researchers will see your answers – me, and the other people working on this project. So your parents/carers or teachers won't know what you have told me.

- There are no right or wrong answers – I'm just asking for honesty and how you feel or what you think about the questions I'm asking
- Also, like before, you don't have to answer any question you don't want to… and you can stop taking part at any time, but we ask if you could answer as many as you feel Ok to answer.

I do need to tell you that if you tell me anything that makes me think you are at a lot of risk, I will need to consult my advisors at the college. If they also think that you are at serious risk, we may need to see how we can help you, but I won't do anything without telling you first.

Now, I need to let you know that I've told ***named teacher at the school*** that I will be interviewing people for my study today – but what you say will remain confidential – I'm just letting you know in case, afterwards you'd like to talk to someone within the school about it.

- If you have any questions, please ask me at any time. And if it's OK with you, I might also take some notes about what you say, during the interview… but I'll try to not be writing too much!

Consent:

- Like in the questionnaire you did, here is a form to say you've heard an explanation about this session and know what you're agreeing to do
- Please read the consent form, - this is exactly the same as the one I sent you with your invitation to this discussion - and if you have any questions, please ask me
- I'll be asking you some questions and making some notes if that's OK, and also I'll be giving you some questions / pages to fill in

- I'd also like to record this – mainly for me to make sure that I'm saying the same thing to all the people I talk to. Would that be OK?

- If it is OK, Would it be OK when I turn the dictaphone on for you to just read out the code number you have been given (on the back of your consent form) and that you agree that we can record what we say today.
- To make sure that the interview stays confidential, I won't say your name during the interview, so in the recording you will be identified by the code number I'll ask you to read out.

Switch on the dictaphone and request the participant reads out the code they have been allocated.

-> topic guide for interview, using the screening questionnaire as a prompt

When required: I've got the other questionnaire that you filled out here with me today, and I was wondering if we could have a look at it and maybe you could tell me a little more about some of the answers you gave in here. Is that OK? Thanks.

Again, just answer as honestly as you can about yourself, and there are no right or wrong answers… I'm just interested in your experience and what you have to say.

If the participant agrees to be interviewed but does not agreed to be recorded: try to explore the reasons for not wishing to be recorded (without pushing them into agreeing to be recorded if they do not want to), to see if you could reassure them about any concerns. Ask if it would be ok to take notes during the interview. The interview can be conducted, with the notes adding to the development of themes and ideas, however, without the transcript, that interview would not be considered as data to be included in the final results.

Debrief

- Thank you for answering all of those questions – It was really good to have a chat with you about those things – and your honesty really helps with the research I'm doing
- Do you have any questions for me?
- As I said everything you've told me will stay confidential here, and will only be looked at for research
- Did you find that OK – I know I was asking you some very personal questions there…

- If some of the things we've talked about have made you think – there are some leaflets up here about health and services in the area… help yourself if you're interested… and just so you know, your school counsellor knew I would be here doing my interviews today – not who I would be interviewing, but it's another person who is there in case you wanted to talk about these issues some more later on.

If the participant mentions displays that he/she is at risk, not only of self-harm but in other ways, or implies that he/she would like to seek help, encourage the young person to approach his/her GP, school counselor or other drop-in service. If this is not feasible, inform participant that their concerns will be mentioned to some of the more senior researchers who have offered to be available for consultation (as per the Child Protection & Risk protocol).It is not the role of the researcher to seek help on behalf of the participant, but there is a responsibility to respond to issues arising in the interviews.
Thank the teacher!

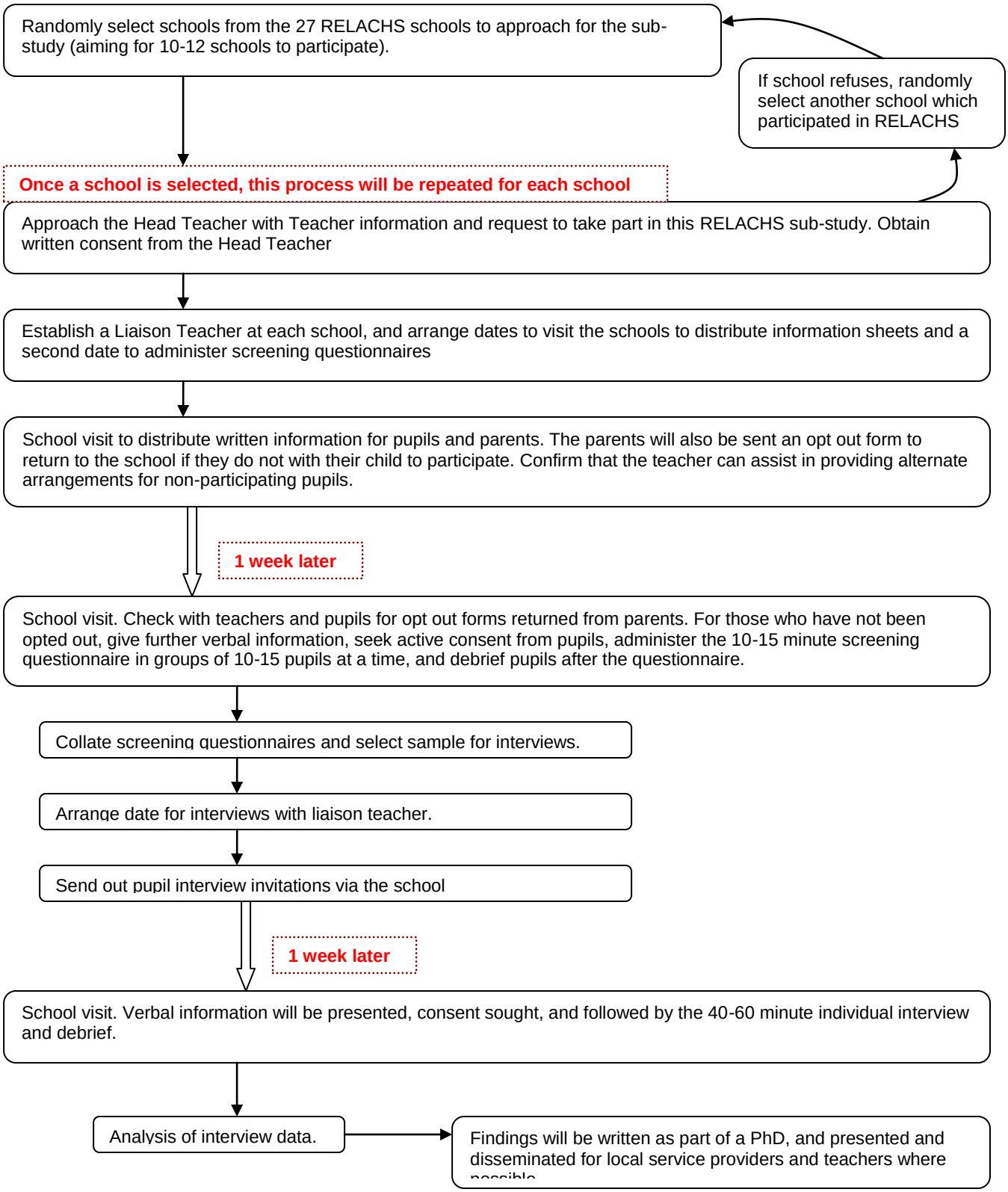
Entry of interview data

The tapes of the interviews will be transcribed by an external transcriber who will be briefed on the confidentiality of the data. The recordings will not make any reference to he name of the participant, and the tapes will be identified by code.

Storage of interview data

- The interview data will be kept in locked filing cabinets at Queen Mary until the end of the study, when the tapes will be destroyed.
- The transcriptions of the interview data will be kept electronically, identified by only code.
- The materials for this part of the study will be destroyed at the completion of the study.

Flowchart for protocol / participation



RELACHS Qualitative Sub-study 2007
Protocol for Child Protection and Risk

This protocol is intended to cover any situations where researchers are provided with or become aware of information, which raises concerns about the safety or well-being of someone who is under 18 years old participating in the RELACHS study. The safety of participants is of utmost importance in conducting this research. This protocol was adapted from that used in earlier phases of RELACHS.

All participants in the study are provided with leaflets for services and contacts for information relating to young people in their area at the end of the session, this will vary by borough, depending on availability of information. If the school feels it is appropriate, the researcher will ensure that the school counsellor is aware of the nature of the research and when it will be conducted.

All information will be kept confidential within the research team. If the researcher thinks that a young person's safety or welfare may be at risk due to any form of abuse from another person, or if the young person may be at risk to him / herself, the following steps will be taken:

1. The researcher would attempt to discuss these concerns in confidence with the participant after that interview/ discussion. If possible the researcher would encourage the participant to seek help, as appropriate, from a school counsellor, their parents, or their GP as the gate-keeper for local CAMHS services.

2. If further action is required, the researcher will then explain that he/she will need to discuss these concerns with senior members of the research team. If the young person agrees, the researcher will take their personal details so that he/she can keep them updated – preferably by personal visit or by telephone or other means if that is not possible.

3. The researcher must immediately report their concerns to the consultation panel including senior member(s) of the RELACHS team Professor Stephen Stansfeld (Professor of Psychiatry) and Professor Kamaldeep Bhui (Professor of Cultural Psychiatry), as well as external consultants Dr Kathleen Brooks (Consultant Child and Adolescent Psychiatrist, Named Doctor for Safeguarding Children, Tower Hamlets), Dr Cathy Lavelle (Consultant Child & Adolescent Psychiatrist. ELCMHT Named Doctor for Safeguarding Children, Newham) and Dr Russell Viner (Consultant in Adolescent Medicine & Endocrinology). This senior panel will make the final decision as to whether the case will be referred to a GP or Social Services as appropriate.

4. If the young person has agreed to provide their address and personal details then s/he will be informed of the action taken preferably by personal visit or by telephone or other means if this is not possible. The researcher will inform the participant of his/her concerns and subsequent discussion with colleagues.

Additional pilot study protocol notes

Interview sample selection

Sample selection for this pilot was undertaken prior to the completion of data collection of RELACHS Phase 3, enabling the study to be arranged before participants had finished that academic year. As few male RELACHS participants had reported self-harm, only females were invited, thus controlling for gender.

Self-harm sample:
All female participants of RELACHS phase 3 at the time of sample selection (20/04/05) who reported self-harm in the past year were invited to participate in this sub-study. This utilised responses from RELACHS 3 questions 36 and 36.1, addressing having ever self-harmed, and whether that episode had been in the last month, between a month and a year ago, or over a year ago, respectively. The study codes for females who had self-harmed in the past year were listed. Data on school class and date of birth was retained, and all other information, including self-harm more than a year ago, was removed.

Non-self-harm sample:
The sample who had not self-harmed were matched by gender, and school class. The non-self-harming sample was selected after a pupil who had self-harmed was selected. The female in the same class with the nearest birthday after the person who self-harmed, (who had not self-harmed) was selected. If the pupil was at the end of the class list, i.e. the youngest person in the class, the next oldest person was selected i.e. the person with the nearest date of birth prior to their date of birth. If there were no other eligible females in the class, the pupil with the closest birthday in the same school (in the other class which participated in RELACHS) was invited. If there were two people who had self-harmed who had consecutive birthdays, the next two non-self-harm birthdates were selected.

Once the sample was selected, names were listed in alphabetical order within each school. The list which was used to compile the information / consent letters and when given to the schools to ask to speak with those pupils had no pattern / ordering to indicate which participants had or had not self-harmed. When the researcher approached the schools and spoke to some of the pupils, she was not aware which pupils had self-harmed.

Invitation to participate in pilot study
Invitations and parental opt out forms were either delivered or posted to each school, depending on whether the pupils were in their last week of school or had left for study leave.

When asked, pupils were not clear about setting dates, other than after their GCSEs (i.e. July), but were informed that the consent was giving permission for them to be contacted to arrange a session in a while. If pupils asked how they were selected, they were informed that the research team had a list of codes from the main RELACHS study, and they some people were selected from each school by their code. If pupils asked what it was about, they were informed that it would involve meeting with a researcher (Emily), for about an hour, to answer some questions about their health (how they felt about things), support and how the cope with things.

Approach to schools for the sub-study:

- Having compiled a final sub-study sample of 112 pupils, the researcher prepared an envelope to invite each pupil to participate in a sub-study. The envelope contained (i) an information letter for the pupil, with a section at the bottom to be torn off and returned with contact details is they were happy to be contacted again to participate in the sub-study, (ii) an information letter for parents/carers with a form to be signed if the parents/carers did not wish their child to participate in the sub-study, (iii) a freepost envelope (iv) a RELACHS pen.
- As this sample selection had taken place in the final week of school, the researcher was not able to visit schools and invite pupils in person at all schools. If pupils were happy to be contacted again, they could sign and return the consent form at that time. Otherwise they were reminded of the FREEPOST envelope.
- Where the researcher was unable to speak with the pupils – usually because they had finished school by that time – the letters were left with a liaison teacher at the school (most commonly the Head of Year 11), with a letter and/ or verbal explanation about the sub-study. Some teachers were happy to

collect in any responses from pupils to return to the research team. Others agreed to encourage the pupils to return their responses in the FREEPOST envelopes they have each been given.

The sample was selected from the raw data that had been entered at the time. Total number of people who had self-harmed in each school / class did change with data cleaning and decisions about what constituted reporting self-harm. Postal questionnaires came in after the sample had been selected as well, and they were not included in the sample, due to timing.

Follow-up
All pupils were sent a letter following their interview, thanking them for participation and offering for help to be followed up if they wished to discuss anything further. If the participant responded the following steps were taken:

- The researcher was to ring the participant again and pass on the details of their local Connexions, and Newham Asian Women's Project (if appropriate).
- If the participant may have further concerns about their health, it might be suggested to talk to their GP and see if the GP could put them in touch with anyone if e.g. CAMHS may be appropriate.
- The participant would be told that if those contacts were not helpful, to contact us again and the research team would see if there were other, places they could be put in touch with.

It was decided that the information would be passed to the young person for her to make contact with the service, as offering to make the contact on the young person's behalf may draw in the research team.

Alterations to structured assessments for this pilot study

Coping style was assessed using the Adolescent Coping Orientation for Problem Experiences; the A-Cope; (Patterson J.M. et al. 1987). The first author was approached about the possibility of using a shortened version of the A-COPE, the A-COPE-S (translated from Swedish) which had fewer questions and factors than the 12 factors from the original full scale (Halvarsson et al. 2001; Patterson J.M. et al., 1987). As a reply was never received from the original authors, the entire A-Cope was used.

The wording of eight items was changed to 'update' the scale, developed in 1987, and make it more appropriate for use with a sample in England. Alterations were also made for greater applicability to those from different religious groups compared with the implied Christianity in the original questionnaire. Two items were added relating to online communication and using the internet.

As these questions were asked of young females, many of whom may be Muslim, to account for the fact that religious practices may differ between religious groups and genders, it was suggested that reading the Quran may be done far more frequently than going to Mosque. This can be done anywhere and may represent a similar sort of use of religious practice in Muslim girls as going to church. This was recommended by Muslim females who felt that asking about going to Mosque did not assess a behaviour engaged in by young Muslim females.

List of A-COPE items adjusted for applicability to the RELACHS sample:

A-Cope Item	Original items from the A-Cope and changes made to questions
17	Changed from 'Ride around in the car' to 'Ride around in a car'
18	Deleted the '("warm fuzzies")' brackets
19	Yell changed to shout
21	Other options to talking to a minister (imam, priest, rabbi) added
23	Other options for go to church (mosque, temple, synagogue) added
33	Changed sewing to drawing
44	Changed liquor to spirits
51	Changed computer games to playstation games

As the scale was developed in 1987, two items were added in response to developments in technology, referring to emailing or communicating with friends online. This may involve chatrooms, specific emails to friends or other web-based communications. Alternatively, simply surfing the net could be used as a coping

method, as a diversion, distraction or actually looking for information. The two items that were added to the end of the list were:

- Email or communicate with friends online
- Surf the net

An open ended question was also added at the end of the list, looking for alternatives to the list provided.

- 'If you do anything else when you are tense or stressed, pleased list:_____'

Child Protection and Serious Danger Protocol for Pilot study
Plan of action for disclosures of child protection issues

This protocol is intended to cover situations where researchers are provided with or become aware of information, which raises concerns about the safety or welfare of someone who is under18 years old. Researchers will hand out to all participants a list of agencies to contact regarding advice and counselling services for participants to contact at either the start or the end of the session. Young people's safety is of paramount importance. If they think that a young person's safety may be endangered, these are the steps which researchers will take:

(i) First, if researchers observe or receive information giving them cause for concern about a young person's safety or welfare, these concerns should be ideally discussed **in confidence** with the participant during or at the end of the interview. The researcher will then explain that s/he will need to discuss these concerns with a senior member of the team who is linked to the study. If the young person agrees, the researcher will take their address and personal details so that s/he can keep them updated - preferably by personal visit or by telephone or other means if this is not possible.

(ii) An exception to this would be if the interview is with a parent, carer or professional rather than the young person themselves and the researcher judges that safety may be further threatened if the parent, carer or professional is informed. If this is the case the researcher will not say anything to the participant about his/her concerns.

(iii) The researcher must immediately report their concerns to Kamaldeep Bhui or Stephen Stansfeld (whoever is the lead researcher at that interview) and they will acknowledge receipt of this in writing.

(iv) In order to decide whether a referral to Social Services is necessary the researcher will contact Kamaldeep Bhui, Stephen Stansfeld, or Russell Viner. One of the consultants will make the final decision as to whether the case will be referred to Social Services or not.

(v) If it is decided that a referral is necessary this will be made within 24 hours of initial contact with the young person. Relevant information and reasons for concerns will be passed to the local Social Service Duty Officer. Any referral made to the Social Services Department in these circumstances will be followed up in writing also within 24 hours.

If the young person has agreed to provide their address and personal details then s/he will be informed of the action taken preferably by personal visit or by telephone or other means if this is not possible. The researcher will inform the participant of his/her concerns and subsequent discussion with colleagues.

Appendix 7: Modified A-Cope for pilot

Modified Adolescent Coping Orientation for Problem Experiences (A-COPE)
When you face difficulties of feel tense, how often do you…

	Never	Hardly	Sometimes	Often	Most of the time
1. Go along with parent's requests and rules	☐1	☐2	☐3	☐4	☐5
2. Read	☐1	☐2	☐3	☐4	☐5
3. Try to be funny and make light of it all	☐1	☐2	☐3	☐4	☐5
4. Apologise to people	☐1	☐2	☐3	☐4	☐5
5. Listen to music or the radio	☐1	☐2	☐3	☐4	☐5
6. Talk to a teacher or counsellor at school about what bothers you	☐1	☐2	☐3	☐4	☐5
7. Eat food	☐1	☐2	☐3	☐4	☐5
8. Try to stay away from home as much as possible	☐1	☐2	☐3	☐4	☐5
9. Use drugs prescribed by doctor	☐1	☐2	☐3	☐4	☐5
10. Get more involved in activities in school	☐1	☐2	☐3	☐4	☐5
11. Go shopping, buy things you like	☐1	☐2	☐3	☐4	☐5
12. Try to reason with parents and talk things out, compromise	☐1	☐2	☐3	☐4	☐5
13. Try to improve yourself (get body in shape, get better grades, etc.)	☐1	☐2	☐3	☐4	☐5
14. Cry	☐1	☐2	☐3	☐4	☐5
15. Try to think of the good things in your life	☐1	☐2	☐3	☐4	☐5

	Never	Hardly	Sometimes	Often	Most of the time
16. Be with a boyfriend or girlfriend	☐1	☐2	☐3	☐4	☐5
17. Ride around in the car	☐1	☐2	☐3	☐4	☐5
18. Say nice things ("warm fuzzies") to others	☐1	☐2	☐3	☐4	☐5
19. Get angry and yell at people	☐1	☐2	☐3	☐4	☐5
20. Joke and keep a sense of humour	☐1	☐2	☐3	☐4	☐5
21. Talk to a minister/ imam /priest /rabbi	☐1	☐2	☐3	☐4	☐5
22. Joke and keep a sense of humour	☐1	☐2	☐3	☐4	☐5
23. Talk to a minister/ imam /priest /rabbi	☐1	☐2	☐3	☐4	☐5
24. Let off steam by complaining to family members	☐1	☐2	☐3	☐4	☐5
25. Go to church	☐1	☐2	☐3	☐4	☐5
26. Use drugs (not necessarily prescribed by a doctor)	☐1	☐2	☐3	☐4	☐5
27. Organize your life and what you have to do	☐1	☐2	☐3	☐4	☐5
28. Swear	☐1	☐2	☐3	☐4	☐5
29. Work hard on school work or school projects	☐1	☐2	☐3	☐4	☐5
30. Blame others for what's going on	☐1	☐2	☐3	☐4	☐5

	Never	Hardly	Sometimes	Often	Most of the time
31. Be close with someone you care about	☐1	☐2	☐3	☐4	☐5
32. Try to help other people solve their problems	☐1	☐2	☐3	☐4	☐5
33. Talk to your mother about what bothers you	☐1	☐2	☐3	☐4	☐5
34. Try, on your own, to figure out how to deal with your problems or tension	☐1	☐2	☐3	☐4	☐5
35. Work on a hobby you have (sewing, football, etc.)	☐1	☐2	☐3	☐4	☐5
36. Get professional counselling (not a school teacher or school counsellor)	☐1	☐2	☐3	☐4	☐5
37. Try to keep up friendships or make new friends	☐1	☐2	☐3	☐4	☐5
38. Tell yourself the problem(s) is not important	☐1	☐2	☐3	☐4	☐5
39. Talk to a brother or sister about how you feel	☐1	☐2	☐3	☐4	☐5
40. Get a job or work harder at one	☐1	☐2	☐3	☐4	☐5
41. Do things with your family	☐1	☐2	☐3	☐4	☐5
42. Smoke	☐1	☐2	☐3	☐4	☐5
43. Watch T. V.	☐1	☐2	☐3	☐4	☐5
44. Pray	☐1	☐2	☐3	☐4	☐5
45. Try to see the good things in a difficult situation	☐1	☐2	☐3	☐4	☐5

	Never	Hardly	Sometimes	Often	Most of the time
46. Drink beer, wine, liquor	☐1	☐2	☐3	☐4	☐5
47. Try to make your own decisions	☐1	☐2	☐3	☐4	☐5
48. Sleep	☐1	☐2	☐3	☐4	☐5
49. Say mean things to people, be sarcastic	☐1	☐2	☐3	☐4	☐5
50. Talk to your father about what bothers you	☐1	☐2	☐3	☐4	☐5
51. Let off steam by complaining to your friends	☐1	☐2	☐3	☐4	☐5
52. Talk to a friend about how you feel	☐1	☐2	☐3	☐4	☐5
53. Play computer games, pool, etc.	☐1	☐2	☐3	☐4	☐5
54. Do a strenuous physical activity (jogging, biking, etc.)	☐1	☐2	☐3	☐4	☐5

Appendix 8: Modified Self Evaluation of Social Support for pilot

Selected questions from the Shortened Self Evaluation and Social Support (SESS) for use in the RELACHS sub-study

O'Connor, P., & Brown, G.W. (1984). Supportive relationships: Fact or fantasy? *Journal of Social and Personal Relationships*, 1, 159-175.

This will be administered orally.

Now I'm going to ask you some questions about people who are close to you, who you might talk to and trust.

Confidants:

If you had a problem of some sort, who would be the first person you would want to discuss it with?	
Who else do you confide in about personal things or worries? (Probe: boyfriend, parents, friends, relatives etc)	

Very close others:

- Ask for a 2-3 relationships -> Who would you say are the 2 or 3 closest people to you?

Write name & relationship		

Ask these questions for each of the named "close others" (person 1, 2 & 3):

Person no. :

How old is…?	
How long have you known….?	
Do you confide in….?	
If yes; What sorts of things do you confide in them about? (about things that worry or upset you?	
Did you just touch on it or go into detail?	
Easily? / With difficulty?	
What about personal things? Do you talk to them about things like that? – or about things that might make them think badly of you?	
Are there any things that you would not talk to them about? (why / why not?)	
Do they ever help you out? (Get details of the last time)	
Did you confide in them about…. (event or difficulty)?	
What did they say? (Did they take your side or were they a bit critical? Sympathetic? Did they offer any advice? How about telling you what to do?)	
Is there anything else you would like to tell me about how you relate to ….	

Appendix 9: Pilot study pupil information

RELACHS Study. BMS Building, Queen Mary College, Mile End Road, London, E1 4NS.
Tel: 020 7882 7648 Fax: 020 7882 7924 Email: Relachs@qmul.ac.uk Web: www.relachs.org.uk

CONFIDENTIAL

Pupil Invitation

Research with East London Adolescents – Community Health Survey (RELACHS) 2005

Dear Pupil,

Thank you for participating in RELACHS in 2005. As promised, we have kept all of your answers confidential, and your questionnaire is currently in a locked filing cabinet at Queen Mary University.

As well as the questionnaire, we are asking a small number of pupils in each school to participate in a sub-study. To do the sub-study we are asking for half an hour of your time to answer some questions individually - so you can tell us a bit more about how you are during this very busy time of your life.

As with the questionnaire, this discussion will be **completely confidential.** Your parents/carers or teachers will not be able to see your answers, only the research team.

Taking part in this study is entirely your choice. If you decide to take part you can stop at any time without giving a reason. If you don't want to answer any question you can miss it out.

To invite you to take part in the sub-study, you will also be given a letter to take home to your parents. That letter says nothing at all about the answers you have given in your questionnaire. If your parents/carers do not want you to participate, we ask them to sign the form and send it back. If they are happy for you to do our sub-study, they don't need to sign or return the form.

If you are worried about any part of the study or want any more information, please ask the researchers or phone Emily Klineberg on 020 7882 7648 or email us: relachs@qmul.ac.uk

We look forward to hearing your point of view.

Appendix 10: Pilot study parent information

RELACHS Study. Room 3.08, MS Building, Queen Mary University of London,Mile End Road,London, E1 4NS.
Tel: 020 7882 7648 Fax: 020 7882 7924 Email: relachs@qmul.ac.uk Web: www.relachs.org

Dear Parents / Carers,

RE: Research with East London Adolescents: Community Health Survey (RELACHS) 2005

RELACHS is an on-going study into the health and well-being of young people in East London. In early 2005 our research team visited over 20 schools, including your child's school and gave pupils a questionnaire to complete. We have surveyed over 1000 year 11s in this area already this year.

In addition to the main questionnaire, we would like to invite some young people to take part in a sub-study. The aim of this study is to ask young people about their support, health and coping strategies at this time in their life.

Our findings are potentially very important in identifying the needs of adolescents in East London, (Newham, Hackney, and Tower Hamlets) and therefore tailoring service provision to benefit your community.

All of the information collected will be kept **strictly confidential** and will **only** be viewed by the research team. No names will be attached to any of the information.

Pupils enjoyed taking part in previous phases of the study, and it has encouraged them to think more about health issues. We have sent a summary of our findings at each stage back to the participants.

What participation will involve for your child…

- An explanation of the sub-study.
- Signing a form to consent to participate. They can opt out at any stage if they choose.
- Answering some questions about their health, support and coping strategies.
- There is also a possibility that we may contact your child in a few years to follow up his/her health.

What this means for parents…

- You are free to choose whether your child participates in the study.
- If you do **NOT** want your child to take part please sign the form on the other side of this page and return it to school **in the next two days**.

Please don't hesitate to contact us on 020 7882 7648 or relachs@qmul.ac.uk if you have any queries about the study. You can also visit our website for more information: www.relachs.org. Thank you very much.

Yours sincerely,
Professor Stephen Stansfeld and Emily Klineberg On behalf of the RELACHS team

Appendix 10: Pilot study parent opt-out form

RELACHS Study. BMS Building, Queen Mary College, Mile End Road, London, E1 4NS.
Tel: 020 7882 7648 Fax: 020 7882 7924 Email: relachs@qmul.ac.uk Web: www.relachs.org

Research with East London Adolescents – Community Health Survey 2005

Parent's Opt -out Form

Only fill in this form if you do **NOT want your child to take part.**

I do NOT want my child _____ to take part in the Research with East London Adolescents – Community Health Survey sub-study being conducted by Bart's and The London School, Queen Mary's School of Medicine and Dentistry, University of London. I have read the information sheet. I know what is required of my child to participate in this study and I do NOT want him/her to participate.

Signed _____

Name in Block Letters _____

Child's Name in Block Letters _____

Date _____

Appendix 11: Pilot study teacher information

Room 3.08, MS Building, Queen Mary University of London, Mile End Road, London, E1 4NS.
Tel: 020 7882 7648 Fax: 020 7882 7924 Email: relachs@qmul.ac.uk Web: www.relachs.org

Information sheet for TEACHERS

Research with East London Adolescents: Community Health Survey – (RELACHS) 2005

Thank you for helping us arrange our successful third phase data collection at your school. At the time of our main data collection, you may recall us mentioning the possibility of following up some pupils for small discussions about health-related issues. We are planning to conduct a small sub-study expanding on questions in our main questionnaire about mental health, social support and coping.

We understand that this is a very busy time of year for teachers and year 11s, but hope that the findings from this sub-study will contribute to improving the well-being of adolescents through exploration of their coping strategies and support.

What this sub-study involves…

We would like to request a morning visit at your school to individually interview 6-8 pupils who took part in RELACHS and have been randomly selected from our class lists. Each interview will take half an hour or less, and will be conducted by a Research Fellow from Queen Mary, University of London, who has an Enhanced Disclosure CRB check.

To conduct these interviews, we would like to request the use of a small room for the morning session of school and assistance in locating the pupils we would like to interview.

As for the main RELACHS study, we have information letters for the pupils and their parents with an opt out form for parents to sign if they do not wish their child to take part. We will prepare these for each pupil we would like to invite into the sub-study, and request that you distribute them a few days prior to our visit.

The pupils will be asked to sign a written consent form to participate in this sub-study on the day, after a verbal explanation about the sub-study. Any pupil who does not wish to participate will not have to and there will be no pressure put on them to participate.

All the pupils' answers will be kept entirely confidential. Only the researchers will have access to the pupil's answers. We cannot disclose their answers to the school, Local Education Authority or any other person or group.

The survey has received full ethical approval by the East London and the City Health Authority Research Ethics Committee. If parents/carers ask you what the study is about please encourage them to phone the research team, the number is 020 7882 7648.

Investigators:

Professor Stephen Stansfeld, University of London
Dr Kamaldeep Bhui, University of London
Dr Charlotte Clark, University of London
Emily Klineberg, University of London

Appendix 12: Pilot study pupil consent form inner page

CONFIDENTIAL

Research with East London Adolescents – Community Health Survey

Pupil's consent form

- I have listened to the explanation about the RELACHS sub study.
- All my questions about the study have been answered and I know what is being asked of me, and how long it will take.
- I agree to answer some written and spoken questions about my feelings and my health.
- I know that I can stop taking part in the study at any time and I don't have to answer any question I don't want to.
- I freely consent to take part in the study. No-one has put pressure on me.
- I will give honest and accurate answers knowing full well that they will be kept confidential.
- I know that if there are any problems, I can contact:

Emily Klineberg, or Stephen Stansfeld on 020 7882 7648

I agree to take part in the study (Please sign)

_____

(Signature)

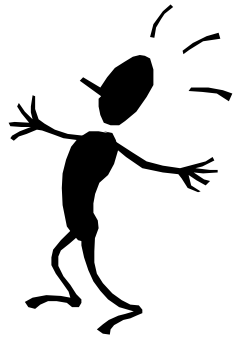
Appendix 12: Pilot study pupil consent form outer page

Code: _____

RELACHS

INVITES YOU

Pupil name



To take part in a sub-study!

Appendix 13: Qualitative study screening questionnaire

Stress, mind and body

This questionnaire is about you – especially things that you find challenging & how you cope with them.

There are many different ways that people deal with challenges. Your thoughts and experiences are important to us. Please answer honestly and accurately.

Everything you write in this questionnaire will be kept confidential, and only seen by researchers.

*** Please mark your responses with a tick ✓ ***

1. Are you female or male? Female ☐ 1
Male ☐ 2

2. What is your Date of Birth? _____

3. How old are you (in years & months)? _____

4. Who do you live with?

✓ ALL boxes that apply

☐ 1 mum
☐ 2 dad
☐ 3 step-dad
☐ 4 step-mum
☐ 5 mum's boyfriend/partner
☐ 6 dad's girlfriend/partner
☐ 7 grandmother
☐ 8 grandfather
☐ 9 in care
☐ 10 other _____

Have any of the following things happened to you *in the past year?*

✓ ONE box on every line

	Yes	No
5.1 Your parents often argued or fought	☐1	☐2
5.2 You were in care / foster home / children's home	☐1	☐2
5.3 Your family had continuing money problems	☐1	☐2
5.4 Your Mum, Dad, sister or brother died	☐1	☐2
5.5 Your parents were divorced or separated	☐1	☐2
5.6 Your parents/carers had a severe illness, injury or operation	☐1	☐2
5.7 You felt distressed or confused about cultural pressures	☐1	☐2
5.8 You or your family experienced a mugging, robbery or burglary	☐1	☐2
5.9 Your parents/carers drank alcohol so often that it caused family problems	☐1	☐2
5.10 You had serious problems with a boy/girlfriend	☐1	☐2
5.11 Your parents/carers expected too much of you	☐1	☐2
5.12 You had trouble keeping up with schoolwork	☐1	☐2
5.13 You were bullied at school	☐1	☐2
5.14 Has any other distressing event occurred involving you, your family or close friends?	☐1	☐2

If you have ticked 'Yes' to 5.14, please describe in the box below, or if you would like to add anything to other answers on the page, please write in this box below.

Please put one tick ✓ on every line to indicate whether you have never thought about doing this, you have considered it, but haven't done it, you have done it once, you have done it occasionally or you do it often.

	Never thought about it	Thought about it, but have never done it	Done this once	Have done this occasionally	I do this often
6.1 Talked to a friend about what was bothering you	☐1	☐2	☐3	☐4	☐5
6.2 Tried, on your own, to figure out how to deal with your problems	☐1	☐2	☐3	☐4	☐5
6.3 Spoken to a teacher/ school counsellor	☐1	☐2	☐3	☐4	☐5
6.4 Taken drugs	☐1	☐2	☐3	☐4	☐5
6.5 Tried to be funny and make light of it all	☐1	☐2	☐3	☐4	☐5
6.6 Became angry and yelled at people	☐1	☐2	☐3	☐4	☐5
6.7 Spoken to a doctor about it	☐1	☐2	☐3	☐4	☐5
6.8 Drunk beer, wine or spirits	☐1	☐2	☐3	☐4	☐5
6.9 Drunk more alcohol than you think you should have	☐1	☐2	☐3	☐4	☐5
6.10 Spent time on your own	☐1	☐2	☐3	☐4	☐5
6.11 Taken an overdose	☐1	☐2	☐3	☐4	☐5
6.12 Harmed yourself in some other way e.g. cut yourself	☐1	☐2	☐3	☐4	☐5
6.13 Talked to a family member about what is bothering you	☐1	☐2	☐3	☐4	☐5
6.14 Listened to music or the radio	☐1	☐2	☐3	☐4	☐5
6.15 Smoked cigarettes	☐1	☐2	☐3	☐4	☐5
6.16 Done risky things because you didn't care	☐1	☐2	☐3	☐4	☐5
6.17 Talked to a priest, imam, minister or rabbi	☐1	☐2	☐3	☐4	☐5
6.18 Emailed or chatted with people online about it	☐1	☐2	☐3	☐4	☐5

7. Which category best describes you? This is your race or ethnic group.

✓ ONE box only

White	White: UK	☐ 1
	White: Irish	☐ 2
	White: Greek	☐ 3
	White: Turkish	☐ 4
	White: Orthodox Jewish	☐ 5
	White: Kurdish	☐ 6
	White: other (please write) _____	7
Mixed	Mixed: White and Black Caribbean	☐ 8
	Mixed: White and Black African	☐ 9
	Mixed: White and Asian	☐ 10
	Mixed: other (please write) _____	11
Asian	Asian: Indian	☐ 12
	Asian: Pakistani	☐ 13
	Asian: Bangladeshi	☐ 14
	Asian: British	☐ 15
	Asian: other (please write) _____	16
Black	Black: Caribbean	☐ 17
	Black: African	☐ 18
	Black: Somali	☐ 19
	Black: British	☐ 20
	Black: other (please write)_____	21
Other ethnic group		
	Chinese	☐ 22
	Vietnamese	☐ 23
	Other (please write) _____	24

That's it! Thank you for taking part!

If you have any other comments you would like to add, please write them in the box below:

Appendix 14: Qualitative study teacher information

RELACHS Study. Room 105, Old Anatomy Building, Queen Mary's School of Medicine and Dentistry, University of London, Charterhouse Square, London, EC1M 6BQ.
Tel: 020 7882 2023 Fax: 020 7882 5728 Web: www.relachs.org Email: e.klineberg@qmul.ac.uk

Information sheet for TEACHERS

Research with East London Adolescents: Community Health Survey (RELACHS)

Sub-study: Stress, Mind & Body 2007

Thank you for the ongoing support of RELACHS from your school. In 2005 we visited and re-surveyed adolescents in 27 East London schools, and have developed sub-studies to explore some of the interesting findings from our main study. We are planning to conduct a small sub-study expanding upon questions in our main questionnaire about stress, social support and coping. We understand that year 11 is a very busy time for teachers and pupils, but hope that the findings from this sub-study will contribute to improving the well-being of adolescents through exploration of support and coping strategies.

What this sub-study involves…

We would like to request a visit to your school to give a brief (10-15 minute) screening questionnaire to year 11s. It would be preferable to survey them in small groups of 10-15 people, but we will adapt around any time available.

Prior to any liaison with pupils or their parents, as outlined below, we will require written consent from the Head Teacher. The form attached to this letter contains all the relevant information for this consent. If you could please copy that information to your school's headed paper and return it to Emily Klineberg we would be very grateful.

As in the main RELACHS study, we have information letters for the pupils and their parents with an opt-out form for parents to sign if they do not wish their child to take part. We will prepare these for each pupil we would like to invite into the sub-study, and request that you distribute them a week prior to our visit. The parent information letters will be available in Bengali, Punjabi, Urdu and Gujarati. If parents do not wish their child to participate, they are to sign the opt-out form and return the letter. We would appreciate your assistance in collecting those letters should they be returned.

Participating pupils will be asked to sign a written consent form on the day, after a verbal explanation about the sub-study. Any pupil not wishing to participate will not have to, and there will be no pressure put on them to participate. Each pupil will be asked to fill out their own confidential questionnaire which will ask about the things they find stressful, and also what they do to cope, such as talking to friends, having time on their own, taking risks, trying out new things, smoking, self-harm, talking to family members or people at school, and so on.

Depending on the answers given in the screening questionnaire, we would like to invite a small number of pupils for an hour-long individual interview to explore these issues at a later date. If it is suitable, Emily Klineberg, who has an Enhanced Disclosure CRB check will conduct the interviews at your school. We would like to request the use of a small space and assistance in locating the pupils for these interviews.

Appendix 14: Qualitative study teacher information, page 2

To prepare for the school visit, we would request a list of the current pupils in year 11, to generate codes. Coding the questionnaires will ensure confidentiality of the information collected, and also to match the initial questionnaire answers with the pupils we would like to interview. Only the researchers will have access to the pupils' answers. We cannot disclose their answers to the school, Local Education Authority or any other person or group.

However, if possible we would like to inform a staff member involved with student support, such as your school counsellor, Attendance Welfare Officer, or link Educational Psychologist about this study as additional options for pupil support, should it be necessary. If you could please supply us with the details of the most appropriate support liaison person within your school, we would be very grateful.

The survey has been given approval by the East London and City Research Ethics Committee, and is covered by indemnity arrangements at Queen Mary, University of London.

If you have any further queries, from you or your school, or if parents /carers have further queries about the study please feel free to contact the researchers directly on 020 7882 2023.

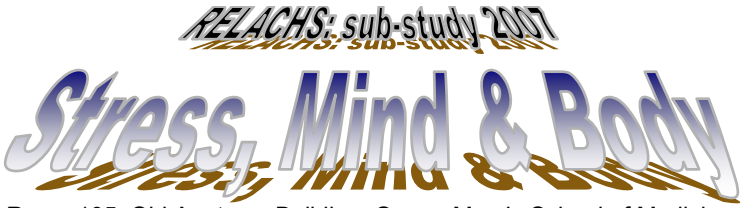
Thank you for your support this research.
Kind regards,

Emily Klineberg

This study is being undertaken as research for a PhD by Emily Klineberg, supervised by Professor Kamaldeep Bhui, Professor Stephen Stansfeld & Dr Charlotte Clark at The Wolfson Institute for Preventive Medicine, Queen Mary, University of London.

If you have a complaint please contact: The Complaints Officer, c/o Chief Operating Officer for the Barts and The London, Queen Mary School of Medicine and Dentistry, Wardens Office, 32 Newark Street, Whitechapel, London E1 2AA.

Appendix 15: Qualitative study Head Teacher consent letter



RELACHS Study. Room 105, Old Anatomy Building, Queen Mary's School of Medicine and Dentistry, University of London, Charterhouse Square, London, EC1M 6BQ.
Tel: 020 7882 2023 Fax: 020 7882 5728 Web: www.relachs.org Email: e.klineberg@qmul.ac.uk

SIGNED CONSENT REQUEST FOR HEAD TEACHERS

Research with East London Adolescents: Community Health Survey (RELACHS)
Sub-study: Stress, Mind & Body 2007

Dear Head Teacher,

Thank you for the ongoing support of RELACHS from your school. If you are in agreement with this sub-study continuing at your school, would you *please copy the following onto your school's headed paper* and return it to Emily Klineberg at the above address;

I have read the information for teachers and give consent for my school to participate in the RELACHS sub-study 2007.

Name: …….

Signature: ……

School: ……

Job title: …….

Date: ……

Please contact me if you have any further queries about the study. Thank you for your time and assistance.

Kind regards,

Emily Klineberg
PhD student

Supervisors
Professor Stephen Stansfeld, University of London
Professor Kamaldeep Bhui, University of London

Dr Charlotte Clark, University of London

Appendix 16: Qualitative study pupil information

RELACHS Study. Room 105, Old Anatomy Building, Queen Mary's School of Medicine and Dentistry, University of London, Charterhouse Square, London, EC1M 6BQ.
Tel: 020 7882 2023 Fax: 020 7882 5728 Web: www.relachs.org Email: e.klineberg@qmul.ac.uk

CONFIDENTIAL

INFORMATION SHEET FOR PUPILS

Research with East London Adolescents: Community Health Survey – (RELACHS) 2007

Dear pupil,
Since 2001 pupils at your school have been helping with a research project based at Queen Mary College, sharing their thoughts, feelings and experiences with our researchers. All of the information young people tell us is kept completely confidential, and only seen by the research team.

We would like to invite you to participate in a study at your school. This will involve a researcher visiting your class, and giving you a short questionnaire which will take 10-15 minutes. Each person will fill out their own confidential questionnaire which will ask about the things you find stressful, and also what you do to cope, such as talking to friends, having time on your own, taking risks, trying out new things, smoking, self-harm, talking to family members or people at school, and so on. A few people from your school will then be asked to meet with a researcher individually - so you can tell us a bit more about how you are during this very busy time of your life. This interview will be up to an hour long, and will be here at your school.

Both the questionnaire and this discussion will be **completely confidential.** Your parents/carers or teachers will not be able to see your answers, only the research team.

Taking part in this study is entirely your choice. If you decide to take part you can stop at any time without giving a reason. If you don't want to answer any question you can miss it out.

To invite you to take part in the sub-study, you will also be given a letter to take home to your parents/carers. That letter says nothing at all about you, other than we would like to invite you to participate in our study. If your parents/carers do not want you to participate, we ask them to sign the form and return it to the school or to the researchers at the above address. If they are happy for you to do our sub-study, they don't need to sign or return the form.

If you are worried about any part of the study or want any more information, please ask the researchers or phone Emily Klineberg on 020 7882 2023 or email: e.klineberg@qmul.ac.uk. You are welcome to talk to the researchers about the issues the study addresses, even if your parents do not wish for you to participate.

We look forward to hearing your point of view.

This study is being undertaken as research for a PhD by Emily Klineberg, supervised by Professor Kamaldeep Bhui, Professor Stephen Stansfeld & Dr Charlotte Clark at The Wolfson Institute for Preventive Medicine, Queen Mary, University of London.
If you have a complaint please contact: The Complaints Officer, c/o Chief Operating Officer for the Barts and The London, Queen Mary School of Medicine and Dentistry, Wardens Office, 32 Newark Street, Whitechapel, London E1 2AA.

Appendix 17: Qualitative study parent information

RELACHS Study. Room 105, Old Anatomy Building, Queen Mary's School of Medicine and Dentistry, University of London, Charterhouse Square, London, EC1M 6BQ.
Tel: 020 7882 2023 Fax: 020 7882 5728 Web: www.relachs.org Email: e.klineberg@qmul.ac.uk

Dear Parents / Carers,

RE: Research with East London Adolescents: Community Health Survey (RELACHS) Sub-study: Stress, Mind & Body 2007

RELACHS is an on-going study into the health and well-being of young people in East London. Between 2001 and 2005 our research teams have visited over 25 schools, including your child's school, and surveyed many young people in East London.

This year we would like to invite the current year 11 pupils to take part in a sub-study. The aim of this study is to ask young people about their experience of stress and the strategies they use to cope with it at this time in their life. We understand that year 11 is a very busy time for teachers and pupils, but hope that the findings from this sub-study will contribute to improving the well-being of adolescents through exploration of their coping strategies and support. Your child's school has given consent for this study to be conducted on school premises, during school hours.

Each pupil will fill out their own confidential questionnaire which will ask about the things they find stressful, and also what they do to cope, such as talking to friends, having time on their own, taking risks, trying out new things, smoking, self-harm, talking to family members or people at school, and so on. Our findings are potentially very important in identifying needs of adolescents in East London, (Newham, Hackney, and Tower Hamlets) and informing service providers to benefit your community.

All of the information collected will be kept **strictly confidential** and will **only** be viewed by the research team. No names will be attached to any of the information given by people who participate.
Pupils enjoyed taking part in previous phases of the study, and it has encouraged them to think more about health issues and what is available for them in the local area.

What participation will involve for your child…

- An explanation of the sub-study.
- Signing a form to consent to participate. They can opt out at any stage if they choose.
- Answering a short (10-15 minute) questionnaire in class groups about their experience of stress and the strategies they use to cope with it.
- The possibility of being invited for an individual interview with a researcher at school to explore issues covered in the questionnaire, in more depth. The interview will be up to an hour in length, and will be exploratory, directed by what each young person has to say.
- There is also a possibility that we may contact your child in a few years to follow up his/her health.

What this means for parents…

- You are free to choose whether your child participates in the study. If you do **NOT** want your child to take part please sign the form on the next page and return it to school **in the next week**.

Please feel free to contact me on 020 7882 2023 or e.klineberg@qmul.ac.uk if you have any queries about the study. You can also visit our website for more information: www.relachs.org. Thank you.

Emily Klineberg

This study is being undertaken as research for a PhD by Emily Klineberg, supervised by Professor Kamaldeep Bhui, Professor Stephen Stansfeld & Dr Charlotte Clark at The Wolfson Institute for Preventive Medicine, Queen Mary, University of London. If you have a complaint please contact: The Complaints Officer, c/o Chief Operating Officer for the Barts and The London, Queen Mary School of Medicine and Dentistry, Wardens Office, 32 Newark Street, Whitechapel, London E1 2AA.

Appendix 17: Qualitative study parent opt-out

RELACHS Study. Room 105, Old Anatomy Building, Queen Mary's School of Medicine and Dentistry, University of London, Charterhouse Square, London, EC1M 6BQ.
Tel: 020 7882 2023 Fax: 020 7882 5728 Web: www.relachs.org Email: e.klineberg@qmul.ac.uk

Research with East London Adolescents – Community Health Survey (RELACHS) 2007

Parent's Opt -out Form

****Only fill in this form and return it to the school if you do NOT want your child to take part.****

I do **NOT** want my child _____ to take part in the Research with East London Adolescents – Community Health Survey sub-study being conducted by Queen Mary's School of Medicine and Dentistry, University of London. I have read the information sheet. I know what is required of my child to participate in this study and I do **NOT** want him/her to participate.

Signed_____

Name in Block Letters_____

Child's Name in Block Letters _____

Child's School in Block Letters _____

Date _____

Appendix 18: Qualitative study teacher visit confirmation

RELACHS Study. Room 105, Old Anatomy Building, Queen Mary's School of Medicine and Dentistry, University of London, Charterhouse Square, London, EC1M 6BQ.
Tel: 020 7882 2023 Fax: 020 7882 5728 Web: www.relachs.org Email: e.klineberg@qmul.ac.uk

VISIT CONFIRMATION AND INFORMATION FOR TEACHERS

Research with East London Adolescents: Community Health Survey (RELACHS) Sub-study: Stress, Mind & Body 2007

Dear *Liaison teacher,*

Thank you for your help with my sub-study at your school. As we agreed, I am intending to visit the school to give small groups of year 11s a brief questionnaire on *date and time during XX lesson*.

Please find enclosed;
- information letters for year 11 pupils *(printed on green paper)*
- information letters and opt out form for year 11 parents *(printed on blue paper)*
- folder for collection of opt out forms

Could one copy of each letter please be distributed to all year 11s one week prior to my visit. If parents do not wish their child to participate, they are instructed to sign and return the opt-out form. Please could you collect the opt-out forms and return them to me on the day of questionnaire data collection.

If possible, I would prefer to work with 10-15 pupils at a time, as they need to have a verbal introduction to the questionnaire, to sign their consent forms and complete their questionnaires privately. If this is not possible, I would request the assistance of a teacher in class with me at the time of data collection. It would also be ideal if we could arrange the pupils to sit separately in exam-style conditions when they are completing their questionnaires.

Following this questionnaire, I will be in touch again to request your assistance in arranging individual interviews with a small number of participants. Ideally these interviews will be around an hour at the end of a school day, or before a break at lunch, however, I am happy to be flexible and adapt around your timetable. I will prepare individual invitations for the pupils I would like to interview, to request your assistance at that time to distribute those letters and let me know if any pupils are not interested in participating in that part of the study. However, I will be in contact about that after completion of these questionnaires.

(If not already established):
I would like to inform your school counsellor about the nature of the study, and when I will be visiting your school. I would appreciate it if you would be able to give me his/her contact details.

Thanks once again for you help.
Kind regards,
Emily Klineberg

Appendix 19: Qualitative study screening pupil consent inner page

CONFIDENTIAL

Research with East London Adolescents: Community Health Sub-Study:

Stress Mind and Body

Pupil's consent form

Please put your initials in the 4 boxes on the right of the page and sign your name at the end to show that you agree to participate.

- I have listened to the explanation about this sub study. All my questions about the study have been answered. ☐
- I know I will be asked some written questions about myself and my feelings that will take 10-15 minutes. ☐
- I freely consent to take part in the study. No-one has put pressure on me. I know that I can stop taking part in the study at any time and I don't have to answer any question I don't want to. ☐
- I will give honest and accurate answers knowing full well that they will be kept confidential. ☐

I agree to take part in the study (Please sign)

_____ _____

(Pupil Signature) (Date)

_____ _____

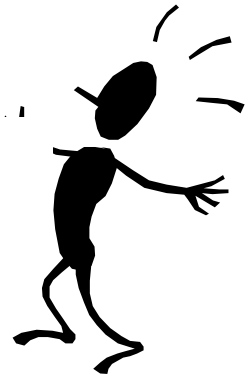
(Researcher Signature) (Date)

Appendix 19: Qualitative study screening pupil consent outer page

Code: _____

RELACHS

INVITES YOU



Pupil name

To take part in a sub-study:

Stress, Mind & Body

Appendix 20: Qualitative study pupil interview invitation

RELACHS Study. Room 105, Old Anatomy Building, Queen Mary's School of Medicine and Dentistry, University of London, Charterhouse Square, London, EC1M 6BQ.
Tel: 020 7882 2023 Fax: 020 7882 5728 Web: www.relachs.org Email: e.klineberg@qmul.ac.uk

CONFIDENTIAL

INVITATION & INFORMATION

Research with East London Adolescents: Community Health Survey (RELACHS)

Sub-study: Stress, Mind & Body 2007

Dear *Pupil's name*,

Thank you for completing the brief questionnaire for this RELACHS sub-study. I would like to invite you for a chat with me at your school. Your teachers agreed that I can talk with you during your citizenship lesson, or after school for about 40-50 minutes, and if you agree, I will make arrangements to be there to meet you at *(add time, date and place, when established).*

I would like to talk with you about yourself, the people around you and also how you are dealing with things you find stressful at this very busy time of your life. There are no 'right' or 'wrong' answers, and we are simply interested in your thoughts, feelings and experiences. Part of the interview will also involve expanding on the answers you gave in the sub-study questionnaire. Like the questionnaire, everything you tell me will be kept **confidential**. Your parents/carers or teachers will not be told your answers, only the research team. However, if you tell me something which indicates you are at serious risk, I will be required to tell my advisors. If that is the case, it will be dealt with very privately and respectfully, keeping you informed.

I would like to record the interview, and to ensure your confidentiality, the recordings will be destroyed at the end of the study.

Taking part in this study is entirely your choice. If you decide to take part you can stop at any time without giving a reason. If you don't want to answer any question you do not have to answer it. If the time and date above is not convenient for you to meet with a researcher, please inform *relevant teacher* or contact the researchers and we will try to arrange another time to meet.

You might remember that your parents/carers were given a letter before you completed the questionnaire. This invitation includes another copy of that letter, as we would now like to invite you for an interview. As for the questionnaire, if they do not want you to participate, we ask that they sign the letter and return it to me at Queen Mary College or your school. If they are happy for you to do our sub-study, there is no need to get in touch. You are welcome to talk to the researchers about the issues the study addresses, even if your parents do not wish for you to participate.

I am also sending you a copy of the consent form I'll be asking you to sign on the day of the interview, so you can have some time to think about whether you agree with what I'm asking. I'll bring another copy of this form on *date of interview*, so this is just to give you time to think about any questions you might have about participating in my study. *Liaison teacher's name* is helping me arrange my study at your school, so *he/she* will know that I'll be talking with you at that time.

If you are worried about any part of the study or want any more information, please phone Emily Klineberg on 020 7882 2023 or email: e.klineberg@qmul.ac.uk. If I do not hear from you, I will expect to see you at the place in the school *at time & date*.

I look forward to hearing your point of view.

This study is being undertaken as research for a PhD by Emily Klineberg, supervised by Professor Kamaldeep Bhui, Professor Stephen Stansfeld & Dr Charlotte Clark at The Wolfson Institute for Preventive Medicine, Queen Mary, University of London. If you have a complaint please contact: The Complaints Officer, c/o Chief Operating Officer for the Barts and The London, Queen Mary School of Medicine and Dentistry, Wardens Office, 32 Newark Street, Whitechapel, London E1 2AA.

Appendix 21: Qualitative study pupil interview consent inner page

CONFIDENTIAL

Research with East London Adolescents: Community Health Sub-Study:

Stress Mind and Body

Pupil's consent form

Please put your initials in the 4 boxes on the right of the page and sign your name at the end to show that you agree to participate.

- I have listened to the explanation about the RELACHS sub study. All my questions about this interview have been answered. ☐
- I agree to answer some questions about myself and my feelings. I will give honest and accurate answers. ☐
- I agree that this interview can be recorded, knowing that the recording will be kept confidential and destroyed at the end of the study. ☐
- I freely consent to take part in the study. No-one has put pressure on me. I know that I can stop taking part in the study at any time and I don't have to answer any question I don't want to. ☐

I agree to take part in the study. (Please sign)

_____ _____
(Pupil Signature) (Date)

_____ _____
(Researcher Signature) (Date)

Appendix 21: Qualitative study pupil interview consent outer page

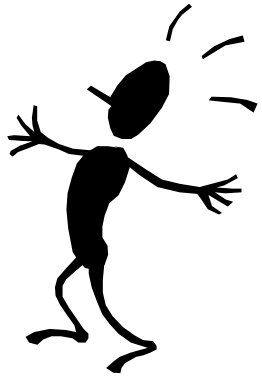
Code: _____

RELACHS sub-study

Stress, Mind & Body

INVITES YOU

Pupil name



To take part in an interview!

Appendix 22: Column titles from all framework charts used in analysis

Column titles from the framework analysis. Each row of the framework matrix contained participant codes, gender, self-harm status from the questionnaire and self-harm status from the interview. See Appendix 23 for an example chart.

Chart titles (page 1)	**Column headings for each chart**	
Sense of self	Self perception	
	Importance of own opinion	
	Importance of others' opinions	
	Roles within family	
	Ownership of actions & sense of control / lack of ownership	
	Clothing & image	
	Religion (also see religion & culture on culture chart)	
Social context and influences	Spare time, image & influences	
	The way he/she relates to others	
	Friends	
	Family	Attitude to family, influences, practices & day-to-day life
		Sense of inclusion / exclusion
		Structure & who they live with
		Perceived parental style & expectations
		Own behaviour with family
	Sense of freedom / lack of freedom	
	School	
	Aspirations	
	Violence, physical aggression & fighting (if mentioned)	
	Where they have lived / feel of area	
	External reasons / explanations for their behaviour	
	Comments about generational differences	
	Employment (if mentioned at all)	
Culture	What is culture?	
	Own culture	
	Influence of culture	
	Culture & family	
	Religion & culture	
	Comments about RELACHS cultural identity question	
Stress & Stressors	Descriptions of emotions	does / doesn't get stressed
		frustrated / annoyed
		feeling angry
		feeling upset
		not happy
	Causes of distress	schoolwork / school
		family / home
		bullying / fighting
		Confusion (if mentioned)
		Other people
		too much to do
	Life events	
	Timing / timescale of problems	

Chart titles (page 2)	Column headings for each chart	
Response to stressors	Time on own	
	What she/he is aiming to achieve when stressed / distressed	
	Attitude to disclosure of distress / seeking help: communication with others & social support	Hiding feelings from others / keeping things to self / bottling things up
		Who to talk to when distressed
		what she/he is looking for by talking to others
		confrontation / talking with the person who made them feel upset / angry / physical confrontation & aggression
		amount that can be disclosed
		important characteristics of confidantes
		Spending time with others as a distraction / something to do
	reasoning responding to stress / distress	
	choosing responses to distress	
	Crying	
	Thinking	
	Does nothing	
	Keeping busy /playing sport / dancing	
	comments about how other people respond to stress / distress	
	perception of control in relation to stressors	
	Expression of emotions through writing / art /singing	
	Acting out / shouting & screaming	
	Apathy / avoiding the problem / giving up / wanting to forget / ignoring it	
	Listens to music / TV	
	reasons NOT to talk to people when distressed	
	Walking away	
	service use (if mentioned)	
Self-harm	Interpretation of self-harm	
	Exposure to self-harm	
	Perceptions of self-harm	Own thoughts
		Perceived acceptability - what others might think
	Own self-harm	- background / triggers
		- description of the harm
		- feeling at time of harm
		- relating to current situation & coping
	Suicide	
	Suggested problems which might influence someone to self-harm	
	Perceptions of why people might self-harm	
	Desire to escape	
	Smoking, drinking, drug use and self-harm	
	Options to consider instead of self-harm	
	Cessation of self-harm / reasons NOT to self-harm	
Self-harm - help-seeking and provision	Own self-harm - disclosure	
	Own response to disclosing self-harm or being found out	
	Disclosure of self-harm by others	
	Own experience - help provision	
	General help provision for people who self-harm	What would be useful
		Who would be appropriate
Social support & communicating with others	Attitude to disclosure of distress / seeking help	
	Who to talk to when distressed	
	what she/he is looking for by talking to others	
	amount that can be disclosed	
	important characteristics of confidantes	

Appendix 23: Extract from a framework chart used in analysis, showing 7 columns

Code	Participant					Interpretation of self harm	Perceptions of self harm - own thoughts
	Int. no.	Sex	Ethnicity	Interview group - from survey	Group - from interview		
O5089	1	F	White-Irish	1 - No SH	1 - No SH	* cutting yourself (206) * emotional harm by putting themselves down (246)	* wouldn't know as she hasn't done it (281, 232) * unsure what people might get out of it (218)
O5082	2	F	Asian Bangladeshi	2 - SH once	2 - SH once	* self cutting (334) * hitting your head on the door (9336-8)	* her self harm wasn't like the 'mad/insane' self harm she'd seen in a movie (443-444) * self harm didn't help (388) * wonders why she did it (370, 346, 348, 450) * self harm as 'a bit crazy', 'mad' (418, 422).
O5013	3	F	White-UK	1 - No SH	1 - No SH	* self harm as self defence (220-222) * taking tablet, drinking (268, 270-4)	* would never take an overdose or self harm (36, 38) * not a good thing to do (230, 232) * doesn't think anyone should do it (232) * people could hurt themselves really badly by self harming (234) * could see that drinking might be disinhibiting - possibly increasing the risk of the harm (268)
O5104	4	F	White-Turkish	2 - SH once	3 - a while ago	* cutting, punching walls (122)	* self harm seems like "what a mad person will do" (352) * temporary relief from anger (362) * punishing herself (340)
O5018	5	F	Black British	2 - SH once	2 - SH once	* overdose (216-231) * slitting wrists (246)	* self harm isn't good (328) * people shouldn't do it (332) * there's no reason to do it (254)
O5068	6	F	Black African	1 - No SH	1 - No SH	* when you hurt yourself (292) * cut yourself (350) * hurt your body (350) * take medicine (350) * cutting self and drawing blood (324)	* not something she'd do or consider even (298, 306) * disgusting (318) * not nice (324, 326)
O5003	7	F	Black British	2 - SH once	3 - a while ago	* harming yourself, cutting yourself (222)	* not the best way of dealing with things (228) * difficult to judge unless you know the story behind it (326) - understandable if there's a serious reason (326-8) * if someone self harms and laughs about it - it seems like it's just for attention (330) i.e. it's something to be taken seriously * idea that if the harming isn't too bad, the person is in control of it (344)
O5085	8	F	Mixed Other	2 - SH once	2 - SH once	* pinching and punching yourself (136)	* feelings of guilt just after her self harm (178) as she felt there could have been other ways to solve the situation (180) * if she could talk to somebody "I wouldn't have to self harm myself to sort things out" (190) - taking about it as something she had to do
O5069	9	F	White Other	3 - SH > once	2 (? 3 implied)	* self harm, definition = harming yourself, cutting (124) * self harm - scratching and cutting yourself (126)	* sees there are other options to consider rather than self harm, you don't have to cut yourself (134) * rather than self harming , you could try to calm yourself down (134) * perceived danger in self harm depends on the method used e.g. a knife is more dangerous than a twig (146) * superficial scratching is being silly, but not really that dangerous if you can't cut yourself (148) * shouldn't self harm b/c it's dangerous (172)
O5086	10	F	Black Somali	2 - SH once	1 - No SH	* ' overdose' (from Q)= taking a missed prescription at the next time she was due to take it (234, 392-6) ** *this is an illustration of how poor my questionnaire question was - without any indication of intent*** * self harm = someone harming themselves intentionally (240) * people cutting their wrists (242) * taking drugs (mentioned spontaneously) = self harm (244, 262) as it harms your body (246) * possibility of harming yourself emotionally mentioned (240-260)* talks around emotional harm e.g. stressing yourself and worrying, but isn't sure you can intentionally hurt yourself emotionally (254-260) * scratches across her arms isn't what you'd call self harm as she wasn't making deep cuts (320-322, 326-8) **implication is that unless you are doing serious damage to yourself, you aren't self harming* (320-326)	* she has not and would not self harm (230) * attitude to self harm - she doesn't like it (302) * self harm is the most stupidest thing ever to do (310) * doesn't understand as she hasn't been in other people's situations and doesn't what they are going through (312-4, 336) * self harm is wrong (316) * self harm is a sick thing to do, not nice (330) * self harm isn't something to boast about (336) * anorexia is like self harming (336) * believes self harm is common in this country (336) * thinks self harming is really stupid as it's against her religion (386)
29085	11	F	Asian Bangladeshi	3 - SH > once	3 - implied	* she did not want to talk about this	* didn't want to talk about it
29134	12	F	Asian Indian	2 - SH once	3 - SH > once	* self harm = pinching herself really badly (243) * self harm = getting yourself injured (269)	* doesn't have an explanation about why it makes her feel better, she just does (279) * feels that she shouldn't do it, as she's the only one who gets hurt from this behaviour - not the person who shouted at her (295)

Code	Participant					Interpretation of self harm	Perceptions of self harm - own thoughts
29118	13	F	Asian Pakistani	2 - SH once	2 - SH once	* talked about considering self-harm(146) when she needed a way out - but she couldn't find it (152) didn't say what she thought self-harm was beyond "a way out" and walking around "not caring" (160) *stigma - feels like an idiot saying that she considered self harm (146)	* thoughts of self harming implied to relate to suicide - no point in killing herself as the problems are able to be solved (148)
29049	14	F	Asian Bangladeshi	2 - SH once	2 - SH once	* "abusing yourself" is drinking, smoking, going out and running wild - the easy way out (458) * self harm = slitting your wrists (460)	* never thought she was going to take an overdose, and has promised herself never to do it again (218) * thinks people who self harm are insecure, not knowing who they are, or what they want (468) * talk about accessibility and acceptability to means (480-2) * cutting yourself with a knife is easy to do (484)
29084	15	F	Asian Bangladeshi	2 - SH once	2 - SH once	* self harm = when people hurt their self (419) when angry or upset (421)	* thinks her OD was silly, in hindsight (257) * self harm doesn't help in any way (287) * her friend would tell her that self harming helps (431) * she can't understand how self harm helps (433) * her friend hasn't been self harming lately, which ppt sees as a good sign (291)
29127	16	F	Sri Lankan Tamil	3 - SH > once	3 - SH > once	* talks about self harm in terms of her own experience - using a sharp object, and having a scar that ran down her forearm, and some odd scars around her elbows (401-406)	references to "scarring" - past tense (402, 414, 436) * trying not to scar herself on the outside as it's unnecessary when you're scarred on the inside (414) * she has learned how the scars make her feel (458) * something that could be "learned" from friends (436) *done when in a "dark place" (458) * something to be hidden - especially from family (408)
29048	17	F	Asian Bangladeshi	2 - SH once	2 - SH once	* self harm = "when someone gets a knife and starts cutting their wrist" (132) * cut yourself scratch yourself - "so many things" (134)	* doesn't think people should self harm (138) * wouldn't do it again (156) * doesn't see having hurt herself as part of who she is (168) * told her friend to stop as self harm doesn't help you in any way (346) * thinks that self harm doesn't get rid of stress beacuse if you're stressed, the stress will just come back (346)
29178	18	F	Black African	3 - SH > once	3 - SH > once	* talks about own self harm - * she goes ages without eating, or recognising she hasn't eaten (96-8) * cuts herself, but also sometimes takes small overdoses, for internal pain - not enough to do permanent damage (120)	* feels likes she's pathetic, and there are other ways to deal with things but she can't bring herself to admit that (203) * having self harmed in part of her identity - as she can't overcome her self harming, she sees herself as weak (331) * doesn't relate to self harm being attention-seeking (392-3) * she focuses on how it would make her feel better, a release from the problem, making the problem from before go away (413) * doesn't think that her culture relates to the ways she copes with things (426-7)
29098	19	F	Mixed White & Black African	2 - SH once	1 - No SH	* has thought about cutting herself, but hasn't (146)	* thought it was funny to ask about cutting yourself (100-2) * has thought about cutting herself (146) * has thought about why people cut themselves and doesn't reallly understand that sort of thing (146) * Doesn't respect people who do things like self harm, and doesn't really like people like that (150) * thinks that if you're going to do it, do it properly (150) * thinks people who self harm are wasting doctors' time when they could be helping others (150) * you don't really know who is self harming (156) *acknowledging the secretive nature of self harm*
22229	20	F	Black Somali	3 - SH > once	3 - SH > once	* she introduces the term 'self harm' after talking about punching walls & herself (282) * seen a documentary about self harm - including people who burn, people who cut, people who punch things - there are different types of self harm (378) * self harm can vary in severity (380) * refers to self harm as "scarring" (442)	* sees her punching walls as a dumb thing to do (256) * laughing a bit while describing early self harm, andcomments that she's not sure why she's laughing about it (256) * thinks it's stupid in hindsight, and can't believe she's done that (258) * sees it as a bit sick describing feeling better with the pain (264) * sees herself as having grown (276) * looking back, she laughs at self harm and thinks there's no point in doing it any more (312-4) * there's not point in self harming (334) * self harm is a waste, and wonders why she did it (336)

	Participant					Interpretation of self harm	Perceptions of self harm - own thoughts
22171	21	M	Asian Indian	3 - SH > once	3 - SH > once		* if he hits a wall, he knows he'll hurt himself, and that's good to hurt something (278-80) * not sure why it's good to hurt himself, he feels much better when he does it (282) * seeing scars on his body make him feel stronger (440)
22198	22	F	Mixed - Other	2 - SH once	2 - SH once	* self harm = try to hurt yourself, maybe try to kill yourself (240)	* thinks people pity themselves (260) *when talking about people who might hurt of kill themselves* * "You don't see the point of living when you're upset, it's like, I don't know, it's confusing" (258) * self harm relates to self pity (262)
26008	23	M	ticked 2 boxes for ethnicity as he was Pakistani and British	3 - SH > once	3 -dep on def'n	not defined - no response to direct Q about self harm * the term 'self harm' doesn't mean anything to him (163-6)	* no thoughts on self harm per se, nor about his wall-punching
26004	24	M	Asian Bangladeshi	2 - SH once	1 - No SH	* self harm = hurting themselves (204)	* thinks people who hurt themselves must be really stressed and not being helped by the people around them (200) *i.e. lack of social support as an influence on self harm, mentioning stress may be from earlier parts of the interview* * thought the person in the movie was crazy (212) * knows people who've hurt themselves by punching a wall for fun, which he thinks is crazy (214-6) * no reason to hurt yourself by punching a wall (220)
22256	25	F	White and Oriental Asian	3 - SH > once	3 - SH > once	* self cutting (157) * hitting a wall isn't as self destructive as cutting (255) * tattoos and piercings could be seen as self harm (255)	* used to see self harm as 'bad' or 'wrong', but doesn't anymore as she's done it, but is over that stage in her life (159) * **"I don't see it as something wrong, it's just a way of coping with stuff. It's like a way of getting your emotions out, it's focusing on something else, other than what's sort of making you angry."** (159) * sees her self harm as a bit of a phase, where "you think it's going to work, but it doesn't" (181) * self harm is an option like listening to music or reading, **"it's something you just try out"** (203) * doesn't see self harm as wrong, but thinks it is pointless and there's no need to do it (265) * notion of harm escalating to be doing irreversible harm - e.g. cutting deeply enough to effect your writing or some other aspect of your life (323) * doesn't think surface scratches or harm every couple of months is a problem (323) *not all-consuming - when self harming, her friends maintain awareness of their image and wanting to look good (345) * harming is a part of your life that nobody else sees, it's not shown (347-9)
29196	26	F	White & Black African	2 - SH once	1 - No SH	* self harm = inflicting pain on yourself (190) * reference to Emos - who have a phase of slitting their wrists (198)	**"I just think she's attention seeking,** because if you ... **if someone really had to self harm and they felt that low, they wouldn't be expressing it to everyone else, because they'd feel so bad within themselves. They wouldn't like be like putting on a show like, "Oh, I have to do this, because I feel so bad." You'd do it and you'd keep it private,** because like she goes around the school like this, and she's all like ... and she puts her sleeves ... pulls her sleeves up, puts her hands to her face and she always looks really depressed" (196)
29001	27	F	Asian Bangladeshi	1 - No SH	1 - No SH	* get a blade or something and have scratches on their hand (116)	* it's OK if her friend has stopped harming (134)
26043	28	M	Black African	1 - No SH	1 - No SH	* doesn't know what the term 'self harm' might mean (214) * self harm = to harm someone (216) e.g. thruogh playing rugby (220)	* self harm : " That's dumb! I don't know." (232) * If he heard of someone who self harmed, he's just let them, and wouldn't get involved (240)
26081	29	M	-999	2 - SH once	1 - No SH	* self harm = suicide, killing yourself,stab yourself, take poison (260)	* self harm = suicide, killing yourself,stab yourself, take poison (260) * a waste of your life (264) * better to just live your life and be yourself than to self harm / suicide, even if you are frustrated or angry (266-8)
26067	30	M	Asian Pakistani	3 - SH > once	3 - SH > once		* "not much to it, really" (134)

Code	Participant					Own self harm - background / triggers	Own self harm - description of the harm
	Int. no.	Sex	Ethnicity	Interview group - from survey	Group - from interview		
O5089	1	F	White-Irish	1 - No SH	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed
O5082	2	F	Asian Bangladeshi	2 - SH once	2 - SH once	* angry with little brother - no specific reason recalled (360-372)	* cut herself once with a knife - in the kitchen - in year 10 (356, 362, 380-4, 460)
O5013	3	F	White-UK	1 - No SH	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed
O5104	4	F	White-Turkish	2 - SH once	3 - a while ago	* anger (148, 154) *was really mad in year 9 (122) * bullied (126) * pressure to do the right thing in other people's eyes (156) * family problems (not specifically linked to the self harm… just generally)	* in year 9 - cut wrists, punching walls (120) * did it a lot in year 9 (356) * once cut herself infront of her little brother (148) * describes her brother's reaction to her self harm - not her reaction - "he was crying", "he went mad" (150)
O5018	5	F	Black British	2 - SH once	2 - SH once	* she felt really down (218) * felt she wasn't needed (220) * mum's overdose (210, 240-2) * it was last year, year 10 (216) * her mum had told her that she'd tried taking a suicidal overdose (210, 340-2) * her mum's overdose influenced her (342)	* took all different types of pills from the cupboard, as a part of an overdose, last year (216-231) * she wasn't thinking at first (228) * doesn't actually recall what happened (218) * "just done it" (220) * stopped herself for the sake of her sister - to not upset her if she didn't wake up and her sister had found her (228-230) * has thought about slitting her wrists (246)
O5068	6	F	Black African	1 - No SH	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed
O5003	7	F	Black British	2 - SH once	3 - a while ago	* lots of anger and self blame (226, 230) * wanted the problems at home to be over (242) * parents not getting along & she didn't have much control over the situation, despite giving her input (244-6) * problems at home had been going on for a long time, since yr 8, worse when she was in yr 9, and finished in year 10 * although she recalls the motivation and feelings before her self harm, she describes it as having 'no reason' (242) * not feeling happy within herself, feeling like she wasn't doing anything right (248)	* cut herself for a couple of days, and then stopped (236-8) * in year 9 (258)
O5085	8	F	Mixed Other	2 - SH once	2 - SH once	* parents arguing, not getting along with her dad (130, 146) * her dad said her parents were separating (168) * * being told off, feeling like life isn't worth living (130) * thought her family was separating (166) * parents not talking to parts of the family (168)	* pinch herself and punch herself (136) * had self harmed once only (162) * didn't remember how it started (171-2)
O5069	9	F	White Other	3 - SH > once	2 (? 3 implied)	* doesn't really remember what was going on at the time when she hurt herself (164) * background 2 years ago - being bullied (162, 164) * own self harm 2 years ago (year 9) (158) * had been at another school in year 9, and there was a lot of bullying and fighting (166)	* self harmed only once (177-178)
O5086	10	F	Black Somali	2 - SH once	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed
29085	11	F	Asian Bangladeshi	3 - SH > once	3 - SH > once	** *this participant had ticked that she self harmed in the questionn aire but did not want to talk about it at all in the interview** didn't want to talk about it	* didn't want to talk about it
29134	12	F	Asian Indian	2 - SH once	3 - SH > once	* loneliness, bullying, sense of rejection and isolation * getting bullied (35, 125) * has been bullied in school since year 7 (109) * feels rejected by everyone (213) * after a death in her family, her mum 'went in a trauma', had depression, stays silent and also had thoughts about not living (37)* feels like she's blamed for upseting her mum, making her angry and more depressed (309) * hurts herself when other people shout at her as she doesn't like being shouted at (283)	* has taken anger out on herself by pinching herself, which leaves temporary marks (243) * marks from her pinching only last 5 minutes (245), or 2 minutes (275) digs her nails into her hand (271) * wouldn't hurt herself in a permanent / "worser" way (271) * puts her hand near her elbow and pinches her other arm (285-289) has done it many times (291)

Code	Participant					Own self harm - background / triggers	Own self harm - description of the harm
29118	13	F	Asian Pakistani	2 - SH once	2 - SH once	* 'had a breakdown' at school (116) * trigger was relating to herself Juliet out of Romeo & Juliet (114-8) * "I felt as if I needed a way out, but I couldn't find one and it was like I was looking for the light at the end of the tunnel, but I couldn't find it because it was so dark everywhere." (152) * couldn't deal with it all anymore (162) * tried a few things, but nothing more (162) *is reference to SH - she's evasive and doesn't say what else she considered* * before the end of year 10 (148) * behind on deadlines at school (152) * things 'mixed up' at school (152) * issues with her family and her boyfriend (152) * felt like she needed a way out - but she couldn't find it (152) * problems with boyfriend and family 'driving me mad' & 'getting to me so much' (152) * most stressful thing is to have restrictions on where she spends her time - sometimes you need to get away from home life or school life (411) * frustrated by the dominance of family life and reputation, and that she can't do what she wants (594, 676)	* thought about self harm (146) * thoughts of self harming implied to relate to suicide - no point in killing herself as the problems are able to be solved (148) * glad she didn't try anything, but did try one thing (154) *usually goes straight home from school (156) but had a patch where she was just walking around (160) *emotion at the time = anger (160) * was listening to music and walking off anywhere - not caring, walking onto the roads, thinking what's the point in doing anything - just crossing roads, even if a car was close (160) * "I don't give a damn any more, just do whatever." (160) * was thinking about getting hurt when she was crossing roads without caring (163-166)
29049	14	F	Asian Bangladeshi	2 - SH once	2 - SH once	* told her mum that her overdose was because of the fighting at home (140) * mum taking sleeping tablets (410) - *available medication ppt has access to…* * parents had their first fight (136) * overdose was 2 years ago, in year 8 or 9 (298-302) * back in year 9, she was really paranoid, and wouldn't come out of her house (528) * thinks what she was saying back in year 9 was bullshit - thinking that nobody cared about her, what's the point (530) * felt like she had Satan in her around the time of her overdose (532) * used to get beaten up and verbally abused at home by her dad when she was young (550) * reference to stabbings and shootings and a friend dying 2 years ago (582) * 2 years ago - wondering what the world is coming to * was 'really going off my block', depressed (586)	* took an overdose of her mum's sleeping tablets (136-8) * was told she could have died after her last overdose (140) * has thought about cutting herself, but never gotten a knife and tried (464-6) * has never cut herself , but once smashed a bottle on her sister's elbow , whch then cut her own foot (486) * sees year 9, when she took her overdose as being a long time ago (538) * *she was quite evasive about her nown overdose...*
29084	15	F	Asian Bangladeshi	2 - SH once	2 - SH once	* anger (253) * in year 9 (251) * no further discussion of the background…	* took some of her mum's pills (245) * the overdose was 'really bad' (243) * took overdose in year 9 (251) * was angry at something and took the pills (253) * the overdose didn't have a good impact on her, and her hands started shaking (253)
29127	16	F	Sri Lankan Tamil	3 - SH > once	3 - SH > once	* first trigger - argument with her parents, who had been shouting (440) * Thinks she 'learned' from her friends who were etching initials into their skin as she would have never contemplated self harming as she doesn't like pain (436) * her parents thought she wasn't achieving what she had potential to achieve, which she interpreted as hating her at the time (468, 470) * started self harming in year 9 (384) *felt very low at time of self harm (386) * low self esteem, and thought that her parents were disappointed in her (388) * felt hated by her parents (390) * felt like everything was going wrong (392) * felt pressured to be more cool, not smart, so she thought "to hell with study", which was quite unlike her (394, 396) * reason for her starting to self harm directed to other people - pressured * in a group who thought self harming was cool (400) * she didn't find self harming cool when she was doing it (400) *highlighting other people doing it influencing her…* story of her friend taking advantage of her admiration, and then finding a new best friend who was etching initials into her arm (428-30) * a friend was 'horrid' to her (436)	* talks about "scarring" herself or when she "got scarred" when she discusses self harm *i.e. it's the scars she's focussing on, not the cutting or scratching- looking at it as the outcome, not relating to the time when she did it.* * used sharp objects to give herself a scar down the length of her forearm (402-406) * had other scars which her parents had seen (406) *her scars were like small dots (<1cm in diameter) on the inside of her elbows* * describes scars as self-inflicted - not accidental as she explained them at the time (412) * hasn't hurt herself recently (414) * the first time she hurt herself she was in her room crying, and was aware of thinking that using a compass would be one way to distract herself from how she was feeling (440) * stopped scarring herself at the end of year 10 (456) * self harmed for a while, not regularly though (456) * didn't think about the fact the scars would help her remember (458) * she didn't find self harming cool when she was doing it (400)
29048	17	F	Asian Bangladeshi	2 - SH once	2 - SH once	* felt like friends were all turning against her - or one girl was turning all of her friends against her (148) * thought that since other people have tried it, she might as well (160) * self harm background * conflict with friends, and felt wrongly accused of something and she didn't want to listen to what a friend had to say (140) * stood up for herself, not doing something that others were encouraging herself to do (144) * blamed by her friends - which she thought was unjustified (146) * felt like friends were all turning against her - or one girl was turning all of her friends against her (148)	* had self harmed once (138) *scratched herself with a knife, with scissors (152) * scratched herself on her arm, but it didn't make a big scar (154) * when she did it she was angry & upset, thinking that it would make her feel better, but it doesn't (158) * hurt herself in year 10 - last year (1824) * her self harm was just to scratch (344)
29178	18	F	Black African	3 - SH > once	3 - SH > once	* " built myself to think when something's wrong, pain is the answer to that problem" (114) * started self harming when she found out she had a half sister and was pretty angry (130-2) * it's like and addiction, and she can't stop (235) * most recent self harm - was stressed - pressure from mum at home, arguments, felt like she had to withdraw from everything (145) * background & triggers - stressed at school, falling behind with schoolwork, and having no-one to talk to about it (269) * arguments between her parents (108) * thinks her parents being separated influenced her self destructiveness (225) * Q 5.9: alcohol causing family problems (227-8) * Q 5.11: family expecting too much (229-30) * family wanting her to be a different person and comparing her with others e.g. cousins (233) * hard always being told she's not good enough (235) * has high expectations of herself (237) * confused why her life is like this, and why she can't talk to anyone about her problem (349-351)* been self harming for 3-4 years (385) * started in year 7 or year 8 (387)	* sometimes she self harms mentioned it spontaneously (96) * if really stressed, she goes ages without eating, or recognising she hasn't eaten (96-8) * cuts herself, but also sometimes takes small overdoses, for internal pain - not enough to do permanent damage (120) * didn't think about it, just did it, and only realised she'd done it afterwards (135) * had been doing it frequently over the last 3-4 years (137) * "had" to cut herself to get a sense of release away from the other problems for a few minutes (147) * doesn't realise she's done things until afterwards (195, 217) * sometimes tries to stop herself (253) * sometimes thinking about her future stops her, but if she's really low, nothing can stop her doing it (263) * she either withdraws from everyone or cuts herself (269) * didn't describe any rituals, just feeling a mix of angry and upset, and just doing it (271) * sees the cutting and overdosing as the same sort of thing (337) * when she's been stressed for a while, eating becomes a burden as she has no appetite and just withdraws herself (341-3)
29098	19	F	Mixed White & Black African	2 - SH once	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed
22229	20	F	Black Somali	3 - SH > once	3 - SH > once	* thinks it was pain and anger tied into one (208) * initial self harm - different situations rolled into one (220) * used to take her anger out on herself when she was a child, but has more awareness and is more intelligent now (200) * her dad passed away, and she'd also felt rejected by her dad as he treated his other children more than her (222) * fathers are supposed to protect & support the family, but he wasn't around, so her mum had to do it all (228) * her mum was ill (244) * she used to get bullied as a kid (244) * she used to worry about other kids making jokes about her - the bullying was mental, not physical (246) * she started self harming, and thought it was dumb & stupid, but it was reinforced as OK when she found out her friend was doing it - and it led her to being in denial about it (344)	* used to punch herself and punch the wall a lot (202) * she once fractured her hand after punching a wall (204) * sometimes used to punch glass (206) * the last time was 2-3 years ago (210) * self harmed for 2 years (348-350) * had marks on her arms (416)

Code	Participant					Own self harm - background / triggers	Own self harm - description of the harm
22171	21	M	Asian Indian	3 - SH > once	3 - SH > once	* he feels angry before he punches things (258) * **he doesn't want to do it, it just happens, he's just angry, sees stuff and hits it (292)** * gets angry very quickly (294) * sees himself as a bad person (376) * doesn't try to stop himself punching walls (393-4) * has been punching walls for the last 2 years (286)	* punishes himself on the boxing bag (250) * when angry, he just punches a pole or a wall (256) * **doesn't want to hit something soft, like a teddy bear, it will get him even more angry as neither he, nor anybody else is hurt (276)**
22198	22	F	Mixed - Other	2 - SH once	2 - SH once	* realisation that people who were meant to be there for her weren't e.g. her mum (244) * argument with step dad (246) * sometimes you" want someone else to be bothered" - but if nobody is, why should you be? (258) - *no self worth, if nobody cares about her, why should she care about herself?* * ongoing disharmony at home, not getting along with step dad, mum and step dad arguing, feeling like mum wasn't ever there to support her * wishes her mum was there for her, as her friends' mums are there for them (286)	* knows at the back of her head she "was not truly going to do it" (242) *implying suicide* * had a blade and scratched her vein (248-250) * doesn't know why she scratched her arm when she did (250) * her sister took the blade from her when she scratched her arm with it (252) * her sister stopped her using the blade, ppt was crying and screaming (254) * went to the window, opened it and put her whole body out the window, standing outside the window (254-6) * her sister held her hands and the top of her body when she was standing outside the window, thinking about jumping to the garden (256-8) * thinks she could have stabbed her hand and not felt it (270) * intentions when she hurt herself & went to the window were to disappear (346)
26008	23	M	ticked 2 boxes for ethnicity as he was Pakistani and British	3 - SH > once	3 -dep on def'n	* hates it when he's late (130) * had anger in himself and didn't want to take it out (134) * not much * anger management, perhaps -* is an angry person (120) * tries to control his anger, and has done so for 2 years (120) * when angry sometimes tries to stop it, but realises what he's done afterwards (120)	* 'rarely' takes his anger out on himself (128) * when he's late, he punches things and bruises his hand, which he realises afterwards (128) * can't get a bruise by punching himself, but he can if he punches a door (146) * harms himself by punching stuff **"I just punch stuff, innit? Like punch everything around me and then I get scars."** (152)
26004	24	M	Asian Bangladeshi	2 - SH once	1 - No SH	* from Q - didn't mean that he'd injured himself on purpose - he has not intentionally hurt himself (194, 198)	N/A - Never self-harmed
22256	25	F	White and Oriental Asian	3 - SH > once	3 - SH > once	* although she knew other options were there, when she was angry she'd scratch herself as she "had nothing else to do when she was angry" (185) * *it's as if she wasn't able to consider the other options when she was angry* * would hurt herself only when particularly stressed (197) * has a couple of friends who do it and a couple who have stopped (167)	* used to self harm & has some scars from it, but she doesn't do it anymore (157) * now she usually hits stuff,like a wall, which is easier, as she's calmed down now (159-61) * was hurting herself last year (year 10) (193) * hits things to do something with her anger, not often though, and wouldn't hit a concrete ball - but it releases built up energy - it doesn't really hurt, but it generally works (209-11)
29196	26	F	White & Black African	2 - SH once	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed
29001	27	F	Asian Bangladeshi	1 - No SH	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed
26043	28	M	Black African	1 - No SH	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed
26081	29	M	-999	2 - SH once	1 - No SH	* he cut himself - but, when probed said it had nothing to do with how he was feeling…	* never taken his feelings out on himself (224) * was cutting some chocolate with a knife, and he cut into his leg - described it as unfortunate and stupid, and nothing to do with feeling angry, when asked (234-245) * did consider that he might cut his leg, just before he did it, but it's described as an amusing accident (238) * cutting his leg had nothing to do with how he was feeling (252)
26067	30	M	Asian Pakistani	3 - SH > once	3 - SH > once	* doesn't know why he first self-harmed (142) * would hurt himself every time the wounds on his arms healed up, about every 5 days (158-60) * would cut himself to let his frustration out (164) * would cut himself if he was bored (198) * excited at the idea of seeing blood- he just wanted to cut himself (204) *trigger for overdose - story about being abducted / kidnapped, which took a while to sink in, and upset him afterwards even though he doesn't remember much (210-222) * overdosed a week after being abducted (220) * Felt that his family was quite against him, not treating him properly, like they'd treat his siblings(108-110) * felt he didn't get as much attention as everyone else - he felt left out in his immediate & extended family (114-6) * problems with his family (208) * felt that his family hadn't been there for him (240) * wasn't getting enough attention from his parents, not that they were being horrible (256-8)	* used to cut himself when frustrated, but he doesn't really do that anymore (132) * cut himself loads of times (134) * "not much to it, really" (134) * started about 2 years ago (138) * took an overdose of paracetamol about 2 years ago (140) *initial 'self harm' while in hospital after an overdose, he scratched his arm with a pen lid (142) *NB He doesn't talk about his overdose as self harm - only cutting/ scratching his arms* * wanted to tell somebody that he wanted to cut himself, or had cut himself (190) * intentions - **"Sometimes I would do it, like, more if I was angry or something to let my frustration out. Sometimes I would do it just for the fun of it. "(194)**

Code	Participant					Own self harm - feeling at time of harm	Own self harm - feelings after self harm ' scars	Own self harm - in relation to current situation & coping
	Int. no.	Sex	Ethnicity	Interview group - from survey	Group - from interview			
O5089	1	F	White-Irish	1 - No SH	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed	N/A - Never self-harmed
O5082	2	F	Asian Bangladeshi	2 - SH once	2 - SH once	* self harm felt a bit weird (392)	* not sure about how it felt afterwards - she went to sleep (364, 370, 396) * after a sleep, she was shocked and didn't understand why she'd cut herself (370) * annoyed that she did it (344-346) * her cutting wasn't an attempt at suicide, but afterwards she realised she could have killed herself (399-404, 375-6, 398)	* wouldn't do it again (388)
O5013	3	F	White-UK	1 - No SH	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed	N/A - Never self-harmed
O5104	4	F	White-Turkish	2 - SH once	3 - a while ago	* punishing herself (154, 340, 354) * relieving anger (154) * importance of seeing the blood - both her and her brother (150-4) * seeing the blood pour out was like seeing her anger go away (358)	* seeing the blood would remove her anger (154) * regret - shouldn't have done it (373)	* currently she just cries and gets angry (180) *distanced from the experience of self harm (368, 373) *"it's been two years now" (354) * " In Year 9 I used to do it a lot, but I've never thought about it now." (356)
O5018	5	F	Black British	2 - SH once	2 - SH once	* didn't want to upset her sister - guilt as she'd forgotten about how it might impact on her sister (228)	* no reason to have taken an overdose (252-4) * doesn't know why she did it (332)	* hasn't thought about it in the last year (326) *
O5068	6	F	Black African	1 - No SH	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed	N/A - Never self-harmed
O5003	7	F	Black British	2 - SH once	3 - a while ago	* releasing anger (226) * don't want to take it out on anyone else (226) * blaming herself for everything (226)	* 'sometimes it can make you feel a bit better' (226) * regretted it (240) * making herself ugly and her arm all scarred for no reason (242) * happy that the problems at home have ended (250)	* sees a big change between now - yr 11- and that time yr 9 when she self harmed (250) * hasn't thought about doing it in the past year (346) * she's always been a happy child, so is happy as she doesn't have problems she had (350-2)
O5085	8	F	Mixed Other	2 - SH once	2 - SH once	* like it's not worth living any more (130) * feeling hurting herself was the only way to express herself (138)	* feeling depressed (132) * it made thing worse - harder for her (140) * felt hurt (174) * guilt (176)	* self harm was 3 weeks earlier - very recent response to distress (146)
O5069	9	F	White Other	3 - SH > once	2 (? 3 implied)	No data	* never been that bothered about it (160) * thinks 'you can't get nothing out of it' (172, 176) * if you self harm you just hurt yourself, nothing else (176)	* doesn't want to do it again (176)
O5086	10	F	Black Somali	2 - SH once	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed	N/A - Never self-harmed
29085	11	F	Asian Bangladeshi	3 - SH > once	3 - implied	* didn't want to talk about it	* didn't want to talk about it	* didn't want to talk about it
29134	12	F	Asian Indian	2 - SH once	3 - SH > once	**'when she sees the mark on herself , she thinks "I've hurt myself, so I feel better" (277)**	* she feels better because of the hurt she's given herself (279) * she tries to stop herself sometimes, if the mark she has caused stays for a long time and looks bad (293) * regrets hurting herself afterwards as she feels the pain (295)	* chooses to hurt herself in a way that leaves temporary marks (245, 275, 293)

Code	Participant					Own self harm - feeling at time of harm	Own self harm - feelings after self harm	Own self harm - in relation to current situation & coping
29118	13	F	Asian Pakistani	2 - SH once	2 - SH once	*emotion at the time = anger (160) * couldn't deal with it all anymore (162)	* talked about the risk taking in a way that she hadn't acknowledged that she might die as a result of her actions (160, 162, 168, 170, 172)	* feels like an idiot saying that she considered self harm (146) * the road-crossing she described was' only a few weeks earlier (160)
29049	14	F	Asian Bangladeshi	2 - SH once	2 - SH once	*"Sometimes you go really mad and you just don't know what to do" (222)	* scared as she could have died (140) * the overdose was scary (218) * was off school for 2 weeks after overdose, didn't want to go (524-6)	* recently has wanted to overdose (140) & thought about it a couple of months ago (220-222) * doesn't think she'd take an overdose, but she does think of it (222) * now she has better ways to sort things out and talk (538) * walks around, cries, letting feelings out (538) * thinks that once you've done it, you wouldn't do it again (take an overdose) (538) * has thought about taking an overdose again, but hasn't actually gone and taken anything again (546) * recently she has drunk and she does smoke, when stressed out, but hasn't done anything too severe (562)
29084	15	F	Asian Bangladeshi	2 - SH once	2 - SH once	* was angry at the time of her overdose (249), but can't remember what (251)	* her overdose didn't help in any way (255) * thinks her OD was silly, in hindsight (257)	* hasn't done it again - only the once (253)
29127	16	F	Sri Lankan Tamil	3 - SH > once	3 - SH > once	* aware of thinking that using a compass would be one way to distract herself from how she was feeling (440) * described feeling "really low", "the lowest" that she thought the pain would go (458) * was "in a dark place" (458) * felt alone at the time she was harming (466)	* her scars now help her remember how she felt (442) *i.e. remembering feeling bad rather than just providing relief*	* trying not to scar herself on the outside as it's unnecessary when you're scarred on the inside (414) * feels like there's been a long period of time since she last got scarred (456) * was "in a dark place" (458) * now she looks more on the positive side (458) * cautious about harming herself again as she has learned how the scars make her feel (458) * currently more focused on the future than dwelling on the darkness in the past and present (460)
29048	17	F	Asian Bangladeshi	2 - SH once	2 - SH once	* had self harmed once, but didn't like it (138) * it didn't hurt at the time, but it hurt afterwards (158) * she felt OK when she was doing it (160)	* it didn't hurt at the time, but it hurt afterwards (158) * it hurt afterwards (160) * having hurt herself made no difference to the problems with her friends (166)	* wouldn't do it again (156) * can't express her anger at school, as she'll get in trouble, but when she's at home she punches pillows (310) * she doesn't punch walls or anything as it would hurt her hands (310)
29178	18	F	Black African	3 - SH > once	3 - SH > once	* has to be in pain or feel pain to take away the other sort of pain she's feeling at the time (116) * pretty angry the first time she hurt herself (132) * feels angry and upset before she hurts herself (151) * always a mixture of feelings - like anger and upset (179) * isn't aware of choosing which she does (339) * "it just happens" (339) * also feels confused (347) * she focuses on how it would make her feel better, a release from the problem, making the problem from before go away (413)	* self harming releases the stress (112) * after she hurts herself she doesn't feel angry anymore, but feels the pain (153) * what she's done hits her a couple of hours later (273) * some form of self reproach afterwards she thinks that there's probably other options to consider (275) * afterwards she goes back to reality, and does remember the problem, and then feels the pain, or feels sick, and gets angry with herself for hurting herself, but knows she can't undo it (419) * sometimes she feels angry that she's hurt herself, and other times she berrates herself as there are other things she could do, other times she doesn't recognise she's done it (421)	* last hurt herself a week ago (143) * responses to distress happen without her thinking (193) * doesn't realise she's done things until afterwards (195) * feels likes she's pathetic, and there are other ways to deal with things but she can't bring herself to admit that (203) * wants to set a good example for her siblings, but also doesn't realise she's doing those things until after she's done it (217) * wonders if she'll reach her goals and ambitions if she carries on doing what she's doing, and she wants to stop, but it's hard (251) * confused why her life is like this, and why she can't talk to anyone about her problem (349-351)
29098	19	F	Mixed White & Black African	2 - SH once	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed	* she wouldn't possibly take an overdose (164) * her mum keeps the medicines in a certain place, implying that she couldn't access it, if she wanted to overdose, but she doesn't (166)
22229	20	F	Black Somali	3 - SH > once	3 - SH > once	* initial self harm - punched a wall and it helped reveal pain and stress, and it just carried on and on (256) * thinks it was pain and anger tied into one (208) * she was so angry, and she sees crying as a weakness and hates crying, so doesn't want to cry, or be seen crying (266-8) * punched the wall for the pain (268)	* revealing pain by punching walls made her feel better (260) * just remembers feeling better (262)	* used to take her anger out on herself when she was a child, but has more awareness and is more intelligent now (200) * sees herself as a stronger person now, so doesn't mind being asked about it (214) * she has times, even now, nearly every week, when she wants to hurt herself, but stops herself as there's no point (354-6)

Code	Participant					Own self harm - feeling at time of harm	Own self harm - feelings after self harm ' scars	Own self harm - in relation to current situation & coping
22171	21	M	Asian Indian	3 - SH > once	3 - SH > once	* angry (256) * he feels calm when he's actually punching a wall, and after (267-9) * when he punches a wall, he feels like killing someone, or doing something bad - so he hits something, so he knows he's done something (272-4)	* after he punches things it hurts, but he feels better (260) * not sure why it's good to hurt himself, he feels much better when he does it (282) * **after he punches a wall, he puts his hand into cold water & doesn't think anything of it (396-8)**	* has been punching walls for the last 2 years (286)
22198	22	F	Mixed - Other	2 - SH once	2 - SH once	*so angry (244) * felt "all the emotions at once" (244) * felt she couldn't take it (258) * **"You don't see the point of living when you're upset, it's like, I don't know, it's confusing" (258) * not bothered - i.e. can't care... (258)** * **at the moment when you're going to self harm - the pain doesn't even seem painful to you (264)** * it didn't hurt at all (268)* she couldn' feel what she was doing as she was so caught up in her emotions (270)	* it hurt afterwards (272) *incident of self harm was a really long time ago, 2 years ago (272-4)	* would never do that now (274) * her sister and watching films and talking to other people made her reaslise that when you have someone there, you can't go on pitying yourself (274-6) * films and documentaries made her realise other people are going through worse things (276) * perspective made her not so caught up in her feelings (276)
26008	23	M	ticked 2 boxes for ethnicity as he was Pakistani and British	3 - SH > once	3 -dep on def'n	* when he punches something, it just feels stiff at the time (150)	* realises after he's done something e.g. punching something which gives him a bruise, and it hurts to touch it, but he denies it affects him (138-144) * can't get a bruise by punching himself, but he can if he punches a door (146) * it hurts, and he feels it afterwards (148) * feels 'nothing' about the scars he gets from punching things (155-6) * doesn't mind if anyone else sees the scars (157-8)	* described as a current approach to dealing with his anger
26004	24	M	Asian Bangladeshi	2 - SH once	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed	N/A - Never self-harmed
22256	25	F	White and Oriental Asian	3 - SH > once	3 - SH > once	* **"when you do it, you don't really think about it. You just sort of do it"** (177) * self harm did work for her at one point, but now she thinks there's no point to it (181) * doesn't think she had any intention beyond releasing energy when she was cutting, the same as hitting a wall (253)	* doesn't have that many scars (199) * not sure how she feels about her scars from her self harm - a reminder of something she did and a part of who she is now (215) * usually went to sleep after cutting herself (259) * after cutting, it felt like she'd gotten rid of something and she could do something else (259) * sees her scars as part of who she is and what she once did (277) * if you're not thinking about it all the time, and it's not a massive part of your life it's not really a problem (323-5) * kept it in perspective i.e. not as important as her friends, her family, going out and having a laugh (329)	* now she usually hits stuff,like a wall, which is easier, as she's calmed down now (159-61) * now she sees she has other options when she's angry * can read when angry (181) * can listen to music when angry(181) * can talk to people when angry (181) * other options are easier to do than harming herself (183) * hitting a wall isn't as self destructive as cutting (255)
29196	26	F	White & Black African	2 - SH once	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed	N/A - Never self-harmed
29001	27	F	Asian Bangladeshi	1 - No SH	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed	N/A - Never self-harmed
26043	28	M	Black African	1 - No SH	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed	N/A - Never self-harmed
26081	29	M	-999	2 - SH once	1 - No SH	N/A - Never self-harmed	N/A - Never self-harmed	N/A - Never self-harmed
26067	30	M	Asian Pakistani	3 - SH > once	3 - SH > once	* his arm scratching didn't really feel like anything, it just hurt (144-6) * described it as feeling weird, and you'd have to do it to know how it feels, as it's hard to explain (164) * had strong thoughts to tell somebody or show somebody going through his head when he self harmed - both before & after- but he's not sure why (178-188) * not aware of how he felt when he cut himself, but he'd feel a bit excited (200) * didn't want to talk about his motivation or feelings at the time of his overdose, saying he didn't remember how he was feeling (223-6)	* scratching his arm calmed him down (150) * his scars don't bother him (282)	* used to cut himself when frustrated, but he doesn't really do that anymore (132)