

**A QUALITATIVE EXPLORATION  
OF THE LINKS BETWEEN  
SELF-HARM AND ATTEMPTED SUICIDE  
IN YOUNG PEOPLE**

**FINAL REPORT**

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## EXECUTIVE SUMMARY

### Introduction and background (Chapter 1, pages 7-12)

1. This document is the final report of a qualitative research study funded by the Scottish Executive's National Programme for Improving Mental Health and Well-being under the Small Research Projects Initiative. The purpose of the study was to explore the links between non-suicidal self-harm and attempted suicide in young people, and in so doing, to identify possible ways of reducing the risk of suicide among young people who self-harm.
2. A previous history of self-harm is one of the strongest predictors of suicide. However, previous research has shown that young people who self-harm often do so for a variety of reasons. Many have no intention whatsoever of taking their own lives. Rather, self-harm is used as a way of coping with psychological / emotional distress and strong feelings which the young person cannot otherwise express.
3. This study sought to explore the processes by which self-harming behaviour, which many would say is intended for coping and survival, can become suicidal. For the purposes of this study, 'self-harm' is defined as an act of self-injury or self-poisoning *which is not intended to result in death*. Self-harm is therefore distinct from 'attempted suicide', which is an act of self-injury or self-poisoning which *is* intended to result in death. Of course, not all suicide attempts *do* result in death, and moreover, some episodes of self-harm may result in death accidentally.
4. The objectives of this study were:
  - To explore young people's own experiences of self-harm and attempted suicide
  - To explore their perspectives on how and why self-harm becomes suicidal
  - Where possible, to analyse differences between young men and young women, and between those who have different preferred methods of self-harm
  - To identify issues which may be relevant to policy and service provision.

### Methods (Chapter 2, pages 13-16)

5. This research involved one-to-one depth interviews with 20 young people aged 14-25 from across Scotland who had experience of both self-harm *and* attempted suicide. Only those individuals who met *both* criteria were eligible to participate.
6. It is important to point out that the acts/behaviours that constituted self-harm were defined by the young people themselves, not by the researcher. Young people were not asked to indicate whether they had ever hurt themselves in certain specific ways. *Rather the young people who took part were left free to say which of their own behaviours they themselves considered to be 'self-harm.'*
7. Young people were recruited through eight voluntary sector agencies across Scotland. Thirteen of the interviewees came from a single agency – Penumbra, which provides self-harm support services to young people in six locations across Scotland. Interviews took place between April and October 2006.

8. The study sample included 8 young men and 12 young women. The young men ranged in age from 14-25 (mean age = 21.75, median = 23.0) and the young women ranged in age from 18-25 (mean = 21.8, median = 22.5).

### **About the young people in this study (Chapter 3, pages 17-22)**

9. The young people who took part in this study were a diverse group with a wide range of backgrounds and experiences. Their lives were complex, and sometimes chaotic. Despite many differences between them, there were also some striking similarities.
10. All the young people who took part in this study had self-harmed for many years. The mean age at which self-harming began was 12.5 (median = 12.0). The mean age of first suicide attempt was 16.2 (median = 17.0). In general, young people had self-harmed for several years before their first suicide attempt. However, two had attempted suicide at the same age at which they began self-harming and four only began self-harming *after* their first suicide attempt. All spoke of suicidal impulses over a number of years which had not been acted on.
11. Multiple life difficulties and serious family problems, in some cases involving physical and / or sexual abuse, neglect and emotional cruelty, were common among this group. All grew up in families that were under pressure in some way.
12. All but three interviewees had been diagnosed with, and received treatment for, depression at some point in their lives. In addition, two young men had been diagnosed with bi-polar disorder, and two young women with borderline personality disorder. Six people had been prescribed anti-psychotic medication at different stages in their lives.
13. The young people in this study all had extensive experiences of services of one form or another. Some of these were positive and some extremely negative. Experiences of being admitted to psychiatric hospital were among the most distressing — particularly if the young person had been admitted compulsorily. It is worth noting, however, that in all cases, experiences of compulsory treatment and detention took place prior to the introduction of the new Mental Health (Care and Treatment) (Scotland) Act 2003, the main provisions of which came into effect in October 2005.

### **Young people's experiences of self-harm and attempted suicide (Chapter 4, pages 23-30)**

14. **Methods of self-harm:** When asked what form their self-harm took, young people gave details of a large range of methods. These were: self-cutting; self-battery; overdosing (taking tablets to cause sickness, but not death); burning; picking / scraping / scratching skin until it bleeds; pulling hair; drug and / or alcohol misuse; and forms of eating disorder (both anorexia and bulimia). Other methods included drinking shampoo, biting oneself, using a screw to puncture the skin and scalding oneself with boiling water.
15. **Methods of attempted suicide:** The following methods were used to attempt suicide: overdosing (often in combination with large quantities of alcohol); hanging or self-strangulation; self-asphyxiation; jumping off a bridge or attempting to jump off a building; deep cutting (veins or arteries in arms or wrists); deliberately crashing a car, or throwing oneself in front of a car; and attempting to shoot oneself with an airgun. Overdosing was the most common method of attempting suicide among both sexes.

16. **Why young people started self-harming:** Young people indicated that their self-harm was initially an impulsive response to difficult life circumstances. It was common for the young people in this study to say that they hadn't known anyone else who self-harmed before they started self-harming. In describing the circumstances in their lives that first prompted them to self-harm, three things were mentioned over and over again — often in combination: (i) being bullied or ostracised at school; (ii) being abused or neglected at home; and (iii) having a serious argument with parents or friends. In addition to these external circumstances, young people explained their reasons for starting to self-harm in terms of how they *felt* at the time – i.e., because they felt lonely, isolated, abandoned, depressed, out of control, frustrated, stressed and/or worthless.
17. **Reasons for continuing to self-harm:** Young people explained their reasons for continuing to self-harm as:
- A way of getting relief from mental / emotional pressure or pain
  - A way of coping with difficult circumstances or the pressures of life
  - A way of escaping or taking a break from difficult circumstances or feelings
  - A way of making themselves feel alive when they felt “numb”, “dead” or “empty”
  - A way of letting off steam, expressing or dealing with anger or frustration
  - A way of punishing themselves (because they don't like themselves or because they feel bad about themselves)
  - A way of having control over something.
18. Some also suggested that, for them, there were times in their lives when they considered their self-harming to be “a cry for help.” Several described their self-harming as a kind of addiction. Young people's recognition of their behaviour (or aspects of their behaviour) as ‘self-harm’ seemed to evolve over time.
19. **The ‘hidden’ nature of self-harm:** In general, interviewees had self-harmed for some time before anyone else became aware of it. However, many also said that their parents had been aware for many years that they were often ill, or always hurting themselves, but the illnesses were always assumed to have a natural cause and injuries were always assumed to be accidental. Although some young people attempted to hide the marks, bruises and scars of their self-harming, others appeared to have made less effort to do so. However, when parents, friends or classmates asked how they injured themselves, a false explanation was usually enough to stop any further inquiry.
20. **Circumstances surrounding suicide attempt:** Some individuals described in detail specific incidents which prompted their suicide attempt(s). However, it was more common for the suicide attempt to be the culmination of a long period of feeling depressed, isolated, stressed and exhausted. It was uncommon for young people to tell anyone they were thinking of killing themselves prior to attempting suicide. It was also not unusual for young people to “change their minds” following an attempted suicide by overdose, and to phone a friend, support worker or ambulance for help.
21. **Contact with services at the time of first suicide attempt:** Thirteen interviewees were already in contact with services at the time of their first suicide attempt. In some cases, this contact was related to depression. In others, the young people were in contact with housing / homelessness services, drug treatment services, social work services, or services related to a physical health problem.

### **The links between self-harm and attempted suicide (Chapter 5, pages 31-36)**

22. In general, young people made a very clear distinction between their self-harm and the times when they had attempted suicide. This was the case even if they used the same methods for both self-harm and attempted suicide.
23. Among those who saw self-harm and suicide as distinct, there was disagreement about whether they were *linked*, or *completely different*. Those who said the two were linked tended to see self-harm on a scale or continuum with suicide at one end. Those who saw them as different felt that they were different simply because the individual's intention was different. For those in this group, suicide became an option when self-harming "didn't work" or when they no longer got any satisfaction from self-harm.
24. Young people said that their self-harming often changed in significant ways just before a suicide attempt. Some said their self-harming became more frequent; others said it stopped altogether, usually because "it wasn't working anymore." It was also common for young people to say that they stopped self-harming for a period of time immediately *after* a suicide attempt.
25. There was a view expressed by some interviewees that people who self-harm know exactly how far they can go before their self-harm is likely to be fatal. However, others suggested that repeated overdoses of paracetamol could lead over time to lowered tolerance levels, and could result in accidental fatal poisoning.

### **Gender differences in self-harming and suicidal behaviour (Chapter 6, pages 37-40)**

26. There did not appear to be major differences in the life circumstances of the young men and young women who participated in this study. Both generally reported multiple serious problems and stressful life events. The main difference appeared to be that several of the young men, but none of the young women, mentioned getting into fights or getting into trouble with the police.
27. All twelve young women and six of the eight young men had attempted suicide on at least one occasion by taking an overdose. However, fewer young men than young women used overdosing as a method of self-harm. In addition, young men appeared to be less likely to have made multiple suicide attempts through overdosing.
28. Five of the eight young men had chosen violent methods to attempt suicide, including hanging, driving a car off a road, jumping off a bridge, etc. Three of the twelve young women had also chosen violent methods to attempt suicide, including hanging and jumping out of a window.

### **Helpful and unhelpful things (Chapter 7, pages 41-50)**

29. Young people were asked about the things, people, activities and services that had been helpful and unhelpful to them over the years. They were also asked *how and why* certain things had been helpful or unhelpful. Their responses focused on friends and social networks; services; medication; parents; self-help; creative outlets (such as writing, painting, singing); and talking.
30. In relation to helpful and unhelpful services, private sector counselling services and voluntary sector services were generally well regarded by this group. Experiences of

NHS services were more mixed. Some were quite positive, others very negative. The experience of being admitted compulsorily to an adult psychiatric ward was considered to be particularly distressing.

31. Young people commonly mentioned the helpfulness of having someone to talk to. The difficulty was in trying to find someone whom they trusted who would truly listen. However, at the same time, interviewees also said that they found it almost impossible to talk to anyone about what was going on in their lives — and that it was very *unhelpful* to be expected or badgered to talk when they weren't ready or able.
32. In considering the question of how to reduce the risk of suicide among young people who self-harm, interviewees made the following suggestions:
  - Schools need to take even greater steps to prevent and deal with bullying.
  - NHS services need to be more responsive to those who ask for help when they are feeling suicidal.
  - Teachers, GPs and NHS emergency staff need to be better trained to know how to respond appropriately and helpfully to young people who self-harm and who repeatedly attempt suicide.
  - Self-harm support groups could be one way of providing young people with support from others who understand them, and could also reduce the sense of isolation that many of them feel.
  - Greater support and intervention (possibly through parenting classes) should be provided to parents.
33. At the same time, it was acknowledged by the young people in this study that they had to be ready to receive the help that was offered to them in order to really benefit from it.

### **Discussion and implications (Chapter 8, pages 51-60)**

34. In general, young people who self-harm see self-harm and attempted suicide as two different things. However, the findings of this study would suggest that they are also closely linked.
35. Self-harm is a symptom of something wrong. The 'something wrong' may relate to the young person's external circumstances but, more importantly, it is an outward manifestation of the young person's internal response to their circumstances. This internal response may include self-hatred, rage, depression, anxiety and despair. All of the young people in this study had had suicidal feelings over a long period of time. Many said that it was their self-harming that kept them alive. However, when the pressures of life became too difficult to deal with, and self-harm no longer seemed to work, then suicide became an option. By the time an individual reaches that point, they have already acquired a great deal of information about what their body can take through self-harm — and so they know that any suicide attempt needs to go that much further.
36. The findings of this study have implications for services, policy and public health and future research. It is important to keep in mind that the young people who took part in this study were recounting experiences which took place over a number of years — in some cases, over 10 years. Service structures and service provision may have changed during that time. Nevertheless, this research indicates that more needs to be done.

37. Young people who self-harm and who are at risk of suicide may be in contact with a wide range of services, including schools, colleges and universities, housing and homelessness services, training and employability services, addiction services, social work services and prisons. Awareness of the issue of self-harm should be raised among staff in these services.
38. On average, young people attempted suicide 4-5 years after they began self-harming. This 4-5 year period provides a crucial window of opportunity to intervene to prevent suicide. A small proportion of the young people in this study attempted suicide before they began to self-harm. These individuals also require help, both to prevent further suicide attempts and to prevent self-harming.
39. For young people who self-harm, and who are contemplating suicide, asking for help is extremely difficult. Increasingly serious episodes of self-harm and repeated overdoses may be an attempt by a young person to seek help. NHS services need to be aware of this, and not dismiss these young people as “attention-seeking”. Negative and judgemental responses by professionals simply reinforce the individual’s beliefs that no one cares about them.
40. Young people felt that having someone to talk to, whom they could trust, and who truly listened was one of the things that helped them most. At the same time, young people have to be given help in ways that feel comfortable to them. Drop-in services, self-harm support groups, and one-to-one sessions with a trusted project worker or CPN were seen as particularly helpful ways of meeting young people’s needs.
41. As part of its focus on improving intervention with people at risk of self-harm or suicide, Scotland’s Mental Health Delivery Plan has made a commitment to train 50% of key frontline healthcare professionals in using suicide assessment tools / suicide prevention programmes by 2010. However, in terms of self-harm, the focus of this commitment is on “people whose self-harming behaviour puts them at high risk of suicide.” The findings of this research suggest that *all* people who self-harm may be, or may become, at risk of suicide. Therefore, professionals need to know how to intervene appropriately in *all* cases of self-harm, irrespective of the person’s assessed risk.
42. In relation to this, the evaluation of the first phase of Choose Life recommended that NICE guidelines on the treatment of self-harm should be adopted in Scotland (NICE 2004). This recommendation has been agreed by the Scottish Executive.<sup>1</sup>
43. The young people in this study reported being adversely affected by the mental health problems of their parents. It may be useful to consider how parents and children in these situations can be better supported.
44. The findings of this study suggest a need for further research on the links between self-harm and suicide in young men. If these young men are in contact with services at all, they are likely to be found in drug / alcohol treatment services, housing and homelessness services and criminal justice services, rather than in services targeted at young people who self-harm.

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<sup>1</sup> The Scottish Executive’s response to the recommendations of the Choose Life evaluation is available from the Choose Life website at: [www.chooselife.net/Evidence/ResearchandEvaluation.asp](http://www.chooselife.net/Evidence/ResearchandEvaluation.asp).

## CHAPTER ONE INTRODUCTION AND BACKGROUND

1.1 This document is the final report of a qualitative research study funded by the Scottish Executive's National Programme for Improving Mental Health and Well-being under the Small Research Projects Initiative. The purpose of the study was to explore the links between non-suicidal self-harm and attempted suicide in young people, and in so doing, to identify possible ways of reducing the risk of suicide among young people who self-harm.

### A note about terminology

1.2 Before discussing the research and policy context for this work, it is important to be clear about the terminology used in this report. Much of the research literature in the field of suicidology uses the terms "self-harm," "intentional self-harm" and "deliberate self-harm" interchangeably to refer to any intentional act of self-injury or self-poisoning (overdose), *irrespective of the apparent motivation or intention*.

1.3 However, in *this* report, the term "self-harm" will be used specifically and consistently to refer to acts of self-injury or self-poisoning *which are not intended to result in death*.<sup>2</sup> Self-harm is therefore distinct from "attempted suicide", which is an act of self-injury or self-poisoning which *is* intended to result in death. Of course, not all suicide attempts *do* result in death, and moreover, some episodes of self-harm may result in death accidentally.

1.4 This report will use the term "deliberate self-harm" *only* when referring to or citing other research literature or policy documents which use this term, or which use the term "self-harm" to refer to both suicidal and non-suicidal self-harm. Where the term "deliberate self-harm" is used in this report, it is important to bear in mind that it makes no distinction between non-suicidal self-harm and attempted suicide, and indeed both types of behaviour are nearly always included.

### Research and policy context

#### *Suicide rates in Scotland*

1.5 Since 1970, the suicide rate in Scotland has been consistently higher than in other parts of the UK.<sup>3</sup> The increasing rates of suicide among men have been a particular cause for concern. Recently published research has shown that, between 1989-2004, female suicide rates increased by 6% whereas male suicide rates increased by 22% (Platt *et al* 2007). In this same 15-year period, suicide rates among Scottish men aged 15-34 were four times higher than those for Scottish women of the same age. Men living in rural and remote areas of Scotland were particularly at risk.

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<sup>2</sup> The report, *Talking about self-harm*, published by NHS Health Scotland, suggests that people who self-harm also prefer the term "self-harm" rather than "deliberate self-harm", since the word "deliberate" has connotations of pre-meditation or careful planning. Acts of self-harm are, in fact, often not pre-meditated (Health Scotland 2006).

<sup>3</sup> See Choose Life website: <http://www.chooselife.net/Statistics/UKComparisons.asp>.

1.6 Since 2000, the suicide rate in Scotland has begun to fall. However, rates for men and women living in Scotland are still about two-thirds higher than in England and Wales (Brock et al 2006).

1.7 In recent years, there has been a serious and determined effort to address Scotland's suicide rate. This work is being taken forward under the Scottish Executive's ten-year Choose Life national strategy and action plan, which was launched in December 2002 and sets a target of a 20% reduction in suicides in Scotland by 2013 (Scottish Executive 2002). The strategy is part of, and operates under the auspices of, the Scottish Executive's work on health improvement and social justice as part of the National Programme for Improving Mental Health and Well-Being. Children and young people (especially young men) are among the priority groups for action on preventing suicide.

1.8 More recently, the Scottish Executive has published *Delivering for Mental Health*, which makes a number of commitments to improve the identification, assessment and care of people with mental health problems. One of these commitments is to train and educate 50% of key frontline healthcare professionals in using suicide assessment tools / suicide prevention programmes by 2010 (Scottish Executive 2006, Commitment 7).

### ***The association between (deliberate) self-harm and suicide***

1.9 A previous history of deliberate self-harm is one of the strongest predictors of suicide (King et al 2001; Morgan & Hawton 2004; Cavanagh et al 1999; Owens et al 2003). Studies of people presenting to hospital following an episode of deliberate self-harm have shown that between 30% and 60% of people who die by suicide have a history of at least one previous episode of deliberate self-harm (Hawton 2005; Cooper et al 2005). One large UK study found that the risk of suicide within one year was 66 times the annual risk of suicide in the general population (Hawton et al 2003), while the National Institute for Clinical Excellence (NICE) has reported that people who have deliberately self-harmed are 100 times more likely than the general population to die by suicide within 12 months (NICE 2002). There is an increased risk of suicide associated with repeated attendances at hospital for an episode of deliberate self-harm (Zahl & Hawton 2004). Moreover, the risk of suicide appears to be greatest within six months after an episode of deliberate self-harm which requires attendance at A&E (Cooper et al 2005).

1.10 There is less evidence available on the association between non-suicidal self-harm and suicide – mainly because of the lack of clarity in the research literature about the distinction between non-suicidal self-harm and attempted suicide. However, one large UK study found that individuals who presented to hospital following an episode of deliberate self-harm and who were identified at the time as having a high level of suicidal intent were significantly more likely to die by suicide within 12 months than those who had a lower suicidal intent (Harriss et al 2005). On the other hand, this same study also found that, of the 54 individuals (30 males and 24 females) who died by suicide within the five-year follow-up period, 37% of males (n=11) and 21% of females (n=5) had previously been identified as having a *low* level of suicidal intent.

1.11 A North American study of non-suicidal self-harm in a community-based sample of young people found that those who had injured themselves more severely were more likely than minor self-injurers to have a history of psychiatric treatment, hospitalisation, suicidal ideation and suicide attempt (Lloyd-Richardson et al 2007). Another American study of 89 adolescents admitted to an adolescent psychiatric inpatient unit found that 70% of those who

engaged in non-suicidal self-harm had made at least one previous suicide attempt and 55% reported multiple attempts. Some of the characteristics of those who made suicide attempts included a longer history of self-harm and use of a greater number of methods (Nock *et al* 2006). While these two North American studies do not provide evidence about an association between self-harm and completed suicide, they clearly do indicate that young people who self-harm are at a high risk of *attempting* suicide.

1.12 The strong association between deliberate self-harm and completed suicide was recognised in the Choose Life strategy and action plan. However, the work of Choose Life is specifically focused on acts of deliberate self-harm which are intended to cause death – that is, those acts which are suicide attempts. Nevertheless, it is worth noting that an independent evaluation of the first phase of Choose Life recommended that greater consideration should be given to the integration of self-harm into the Choose Life strategy. In particular, the evaluation team recommended that the strategy should continue to include the high-risk end of self-harm, but felt that the ‘less serious’ component of self-harm could not be ignored (Platt *et al* 2006).

### ***Self-harm among young people***

1.13 Previous research has shown that young people who self-harm often do so for a variety of reasons (Rodman *et al* 2004; Hawton *et al* 2006). Many have no intention whatsoever of taking their own lives. Rather, self-harm is a way of coping with psychological / emotional distress and strong feelings which the young person cannot otherwise express or resolve. Self-harm can be a way of expressing anger or self-hatred, relieving tension or pressure, and dealing with extreme sadness or depression (NHS Health Scotland 2006).

1.14 Young people who self-harm do not always come to the attention of services as a result of their self-harm, and therefore statistics based on hospital attendances significantly under-represent the actual prevalence of self-harm in this population. Our best information about the prevalence of self-harm among young people in the UK comes from a large community-based survey of 15- and 16-year-old school pupils in England undertaken by Keith Hawton and colleagues in 2000-2001. This study was part of a larger international study, called CASE (Child and Adolescent Self-harm in Europe) involving six other countries (Ireland, The Netherlands, Belgium, Norway, Hungary and Australia). The survey involved asking young people whether they had ever harmed themselves intentionally. If they answered yes to this question, they were then asked to describe what they had done. Those who did not answer this latter question, and those who indicated that they had *thought* about harming themselves, but implied that they had not actually *done* so, were not recorded as self-harming. Those who reported ever harming themselves were also asked to describe in their own words why they did what they did. They were also asked to choose from a list of eight possible motives all those which they felt explained why they had harmed themselves (Hawton *et al* 2006, p. 29).

1.15 This study found that 10.3% of young people (16.7% females and 4.8% males) in England reported having deliberately tried to harm themselves at some point in their lives. Deliberate self-harm *in the past year* was reported by 6.9% (11.2% females and 3.2% males). Only 12.6% of the incidents of deliberate self-harm described by these pupils resulted in a hospital visit (Hawton *et al* 2006). Interestingly, in all seven countries involved in the CASE study (including England), the prevalence of self-reported deliberate self-harm was found to be higher among females than males (Hawton *et al* 2006, p. 45).

1.16 Note that the figures reported in the paragraph above include both suicidal and non-suicidal self-harm. Of those who reported an episode of deliberate self-harm, very few spontaneously said that their reason for self-harm was because they “wanted to die” (Rodham *et al* 2004). However, when asked to select from a list of eight possible reasons, about 53% said that one of their reasons was because they “wanted to die” (Hawton *et al* 2006, p. 53). Nearly three-quarters (73%) of the young people in this study said that their main reason for self-harming was “to get relief from a terrible state of mind”.

1.17 Growing concerns about an apparent increase in the prevalence of self-harm among young people in the UK led to the launch, in 2004, of the two-year *National Inquiry into Self-Harm among Young People Aged 11-25*. One of the main purposes of the Inquiry was to gather evidence about self-harming behaviour which had hitherto not been well-studied because the young people who engage in these behaviours are not necessarily in contact with services (Mental Health Foundation 2006). Thus, the Inquiry focused on self-harming behaviours such as cutting, burning, scalding, banging, breaking bones, hair pulling and ingesting toxic substances or objects. The Inquiry acknowledged that behaviours such as drug and alcohol misuse, eating disorders, and risk-taking behaviour such as unsafe sex and dangerous driving could also be classed as self-harm, but it was felt that these behaviours were more widely recognised, and perhaps better understood, and so the Inquiry did not include these forms of self-harm within its remit.

1.18 The Inquiry gathered evidence from a variety of sources, including from young people who self-harm. Some of the findings of the Inquiry indicated that:

- Self-harm is more common among young women than young men, and
- Self-cutting is the most common method of self-harm, followed by overdosing.

1.19 Interestingly, in relation to the former point, it is perhaps worth noting that Scottish hospital statistics from 2004 show that the incidence of *hospital-treated* self-cutting was higher among young women than young men in the 15- to 19-year age group, but in the 20- to 24-year age group, the rate was higher among men (ISD 2004, cited by the National Inquiry).<sup>4</sup>

1.20 The findings of the National Inquiry also confirmed previous research that many young people who self-harm do so with no intention of killing themselves. Rather, self-harm is a symptom of an underlying emotional or psychological problem or trauma, which must be addressed if the self-harming behaviour is to be resolved. The Inquiry report, *Truth Hurts*, argued that self-harm is a major public health issue, and levels of self-harm are an important indicator of the mental health and well-being of young people in society (Mental Health Foundation 2006, p. 5).

1.21 The National Inquiry has made an enormous and important contribution to our understanding of self-harm among young people. However, it did not address the question of how self-harm can become suicidal. Furthermore, as mentioned above, it is important to keep in mind that even self-harming behaviour which is *not* intended to cause death has the potential to result in accidental death.

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<sup>4</sup> This data was originally published on the Scottish Parliament website, in response to Parliamentary Question PQ-S2W-24733, lodged on 28 March 2006.

1.22 How and why does self-harming behaviour, which many would say is intended for coping and survival, become behaviour which is intended to end one's life? These questions are the focus of this study.

### **Aims and objectives**

1.23 The aim of the research was to explore the links between non-suicidal self-harm and suicide in young people — to understand the processes by which self-harming behaviour becomes suicidal. This was done by interviewing young people who had a history of self-harm **and** attempted suicide. The objectives of the research were:

- To explore young people's own experiences of self-harm and attempted suicide.
- To explore young people's perspectives on how and why self-harming behaviour becomes suicidal.
- Where possible, to analyse differences in perspectives between young men and women, and between those who have different preferred methods of self-harm.
- To identify issues which may be relevant to policy and service provision.

### **Structure of this report**

1.24 The following chapter describes the methods used in this study. The focus will be on how young people were recruited into the study, and the topics covered in the interviews. This chapter also provides basic information about the sample, such as the number of males and females, and the age range and geographical distribution of participants.

1.25 **Chapter 3** provides a fuller description of the young people who took part in the study.

1.26 **Chapter 4** looks at young people's experiences of self-harm and attempted suicide. Again, this chapter is largely descriptive in nature.

1.27 **Chapter 5** examines the links between self-harm and suicide. It will show how, according to young people, self-harm and suicide are different and how they are similar. It will also show how and why young people's motives and behaviours change in relation to a suicide attempt.

1.28 **Chapter 6** compares the experiences of young men and young women in relation to self-harm and attempted suicide.

1.29 **Chapter 7** provides a summary of the sorts of things (people, services, activities) which young people said have been helpful to them and those which have been particularly unhelpful. This chapter also reports what young people themselves feel could be done to prevent suicide among people who self-harm.

1.30 Finally, **Chapter 8** highlights some of the implications of this work for policy, service provision and future research.



## CHAPTER TWO METHODS

2.1 This research involved one-to-one depth interviews with 20 young people from across Scotland who had experience of both self-harm *and* attempted suicide. Only those individuals who met *both* criteria were eligible to participate.

2.2 It is important to point out that the acts/behaviours that constituted self-harm were defined by the young people themselves, not by the researcher. Young people were not asked to indicate whether they had ever hurt themselves in certain specific ways. *Rather the young people who took part were left free to say which of their own behaviours they themselves considered to be 'self-harm'.*

2.3 On the other hand, it was felt there could be some difficulty in identifying young people who had attempted suicide. It was assumed that young people who self-harm would have suicidal thoughts and intentions which they may, or may not, have ever acted upon. However, for the purposes of this study, it was important to recruit *only* those who had acted upon those thoughts and tried to kill themselves. Therefore, suicide was defined as an act which the young person had carried out *with the intention of ending their life.*

2.4 The original plan for the study was to interview young people aged 16–25 and to recruit all interviewees through a single agency — Penumbra. Penumbra provides self-harm support services to young people in six locations across Scotland. Four of these services are funded entirely by Choose Life. The aim was to sample so as to ensure a roughly even spread of age, geographical location and gender. Of these three variables, gender was seen to be the most important because previous research suggests that young women are more likely than young men to self-harm, but young men are more likely than young women to complete suicide.

2.5 Difficulties in recruiting young men into the study via Penumbra resulted in a decision to expand the study to include other voluntary sector agencies. Continued difficulties in recruiting young men resulted in a further decision to lower the age of participation to 14, in order that young men living in secure accommodation might be able to be included.<sup>5</sup> (See Chapter 6 and the annex of this report for further information about the difficulties this study encountered in recruiting young men.)

2.6 A very large number of voluntary sector agencies across Scotland were approached about the study and invited to participate. These included agencies targeted at:

- Young people with mental health problems
- Young homeless people
- Young people with drug and alcohol problems
- Lesbian, gay, bi-sexual and transgender young people
- Those living in secure accommodation
- Those involved in the youth justice system.

2.7 Seven agencies apart from Penumbra agreed to participate in the study, and one young person from each of these agencies was interviewed. In order to protect the anonymity of these individuals, the names of the other agencies are not listed here.

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<sup>5</sup> Secure accommodation services in Scotland are provided to young people aged 16 and under, who are considered to be a risk to themselves or to others.

## **Ethical issues, including participant recruitment and consent procedures**

2.8 It was assumed that many, if not all, of the young people who took part in this study might be at risk of suicide simply because of their previous history of attempted suicide. Therefore, stringent ethical procedures were followed throughout the study. These were informed initially by ethical guidelines published by the Social Research Association and Barnardo's.<sup>6</sup> However, procedures were further developed through consultation with practitioners from the Penumbra self-harm services. The over-riding consideration was to protect all research participants from any harm which could result from their participation.

2.9 Young people were told about the study by their project worker. Project workers only approached individuals who: (a) they believed met the criteria for participation *and* (b) whom they felt were emotionally strong enough to be interviewed on this subject.

2.10 Young people who expressed an interest in the study were given an information leaflet (prepared in advance by the researcher). This explained the purpose of the study, who was funding it, what participation would involve, what topics would be discussed, the possible advantages and disadvantages in taking part, and what would happen with the interview data. Procedures for maintaining the anonymity of interviewees were described, and it was clearly explained that the researcher would not tell *anyone* — not even the young person's project worker — what they said during the interview. The only exception would be if they disclosed something which indicated that they, or someone they knew, was in danger, in which case the researcher would *have* to tell their project worker, but would discuss this with them first.

2.11 If, after reading the leaflet, the young person was still interested in taking part, their project worker asked for permission to pass on their phone number to the researcher. Those who agreed were contacted within one or two days. During this initial telephone discussion, the researcher went through the entire information leaflet again to ensure that the young person understood it and that they met the criteria for participation in the study. At this point, unless the young person said that they definitely wanted to participate (which most did), the researcher offered to meet with them, or phone them back again in a few days, to answer any questions they might have. Those who agreed to participate were told that they could change their minds later, and that they would not have to give a reason for this.

2.12 In relation to the possible disadvantages of taking part, it was clearly explained to all young people both verbally and in writing, that discussion of the circumstances surrounding their self-harm and previous suicide attempts could raise difficult and painful memories, which might make them feel upset. Young people were encouraged to speak to their project workers again before deciding to participate if they had any concerns at all that the interview could upset them. In addition, all young people were told that they could have a friend or project worker attend the interview with them, if that would make them feel more comfortable, and that they could stop the interview at any time if they were finding it difficult.

2.13 In relation to this, it is worth noting that prevailing expert opinion indicates that discussing the topic of suicide with individuals who have suicidal thoughts does not increase the risk of their acting upon them. In fact, encouraging people who feel suicidal to discuss

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<sup>6</sup> Barnardo's Statement of Ethical Research Practice. Available at: <http://www.barnardos.org.uk/ethical.pdf>.  
Social Research Association (2003) *Ethical Guidelines*. Available at: <http://www.the-sra.org.uk/documents/pdfs/ethics03.pdf>.

their feelings with a sympathetic and understanding listener is believed to reduce an individual's risk of suicide. It is for this reason that help-lines such as Samaritans and Breathing Space have been set up.<sup>7</sup> Throughout the interview, the researcher was constantly alert to any signs of distress in the young person, and made it a point to ask the interviewee at various points if they would like to stop and take a break.

2.14 Arrangements were made to provide the young person with debriefing time with their project worker immediately following all interviews.

### ***Reimbursement of expenses / Use of incentives***

2.15 The young people were told that all travel expenses they incurred through participation in the study would be reimbursed. A decision was initially taken *not* to offer potential interviewees any other incentive to participate. However, all interviewees were sent a letter after the interview, along with a £10 gift voucher, to thank them for their participation.

2.16 This arrangement worked well in recruiting young people through Penumbra. However, once it became necessary to recruit young people through other agencies, the question of offering an incentive had to be revisited. Managers in some agencies felt it would be useful to tell the young person in advance that they would be given a voucher, although many also said that a £10 voucher was unlikely to make a difference to anyone's willingness to participate.

2.17 Therefore, a decision was taken to discuss this issue on a case-by-case basis with every agency that was approached to take part. If the agency worker felt it would be helpful to offer an incentive, then the £10 voucher was mentioned in the project information leaflet in addition to the reimbursement of travel costs. If the worker felt it was unnecessary to offer an incentive, the voucher was not mentioned. However, in every case, the young person received the voucher. Some knew in advance that they would receive this; others were not told until after the interview.

## **Interviews**

2.18 Interviews took place from April – October 2006 and covered the following topics:

- Young people's experience of self-harm (what form this took, why they started, why they continued)
- Their experience of attempted suicide (what form this took, and what the circumstances were)
- What they saw as the links, or differences, between self-harm and suicide
- Their experiences of services, or seeking / receiving help
- Things that had been helpful and unhelpful to them

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<sup>7</sup> See, among others: Breathing Space website ([www.breathingspacescotland.co.uk](http://www.breathingspacescotland.co.uk)); PAPYRUS (2006) *Not Just 'A Cry for Help'* ([www.papyrus-uk.org/pdf/njacfh.pdf](http://www.papyrus-uk.org/pdf/njacfh.pdf)); Choose Life website ([www.chooselife.net/AboutSuicide/suicidethemyths.asp](http://www.chooselife.net/AboutSuicide/suicidethemyths.asp)); ChildLine (2002) *Suicide. Information Sheet 6* ([www.childline.org.uk/pdfs/info-suicide.pdf](http://www.childline.org.uk/pdfs/info-suicide.pdf)); World Health Organisation (2000): *Preventing Suicide. A Resource at Work* ([whqlibdoc.who.int/publications/2006/9241594381\\_eng.pdf](http://whqlibdoc.who.int/publications/2006/9241594381_eng.pdf)) and *Preventing Suicide. A Resource for General Physicians* ([www.who.int/mental\\_health/media/en/56.pdf](http://www.who.int/mental_health/media/en/56.pdf)); Kids Health website ([www.kidshealth.org/teen/school\\_jobs/good\\_friends/talking\\_about\\_suicide.html](http://www.kidshealth.org/teen/school_jobs/good_friends/talking_about_suicide.html)).

## Use of quotations

2.19 To ensure the anonymity of the young people who participated in this study, quotations throughout this report are attributed only by the interviewee's gender and age. This information is given in order that the reader might be able, to some extent, to imagine the young person who said these things. A decision was taken *not* to give each individual a pseudonym. The reason for this was to avoid a situation whereby a reader could, even inadvertently, piece together the quotes of particular individuals and so begin to have enough information about that individual that the young person could (potentially) be identified.

## Sample description

2.20 The study sample included 20 young people — 8 young men and 12 young women from around Scotland. The young men ranged in age from 14–25 (mean age = 21.75, median = 23.0), and the young women ranged in age from 18–25 (mean = 21.8, median = 22.5). Half of the interviewees were aged between 23–25. See Table 2.1 below.

2.21 Interviewees were predominantly recruited from urban areas or large towns. Thirteen of the interviewees were recruited through the Penumbra self-harm services in different areas of Scotland. A substantial number of the female interviewees were recruited through the very busy Penumbra service in Edinburgh. See Table 2.2. Possible sample bias will be discussed in the Conclusions (Chapter 8).

2.22 The majority of the interviewees were single. However six of the 20 (two men and four women) were married or living with a partner. Four of these (two of the women and both men) had children. One of the men also had children from a previous relationship who were not living with him.

**Table 2.1: Age and sex of interviewees (n=20)**

	<b>M</b>	<b>F</b>	<b>Total</b>
<b>14-18</b>	1	2	3
<b>19-22</b>	3	4	7
<b>23-25</b>	4	6	10
<b>Total</b>	<b>8</b>	<b>12</b>	<b>20</b>

**Table 2.2: Geographical distribution of interviewees (n=20)**

	<b>M</b>	<b>F</b>	<b>Total</b>	<b>Rural / small towns*</b>	<b>Urban / large towns*</b>	<b>Total</b>
Aberdeen City	—	2	2	—	2	2
Borders	1	1	2	2	—	2
Dundee City	—	1	1	—	1	1
Edinburgh City	4	5	9	—	9	9
Fife	—	1	1	—	1	1
Greater Glasgow	1	—	1	—	1	1
Highland	—	1	1	1	—	1
North Lanarkshire	1	—	1	—	1	1
North Ayrshire	1	1	2	—	1	1
<b>Total</b>	<b>8</b>	<b>12</b>	<b>20</b>	<b>3</b>	<b>17</b>	<b>20</b>

\* Based on the Scottish Executive's six-fold urban rural classification, available at: <http://www.scotland.gov.uk/Publications/2006/07/31114822/5>.

## **CHAPTER THREE ABOUT THE YOUNG PEOPLE IN THIS STUDY**

3.1 The previous chapter provided very basic information about the study sample. This chapter gives a more detailed description of the young people who took part in the study. The aim is to provide a context for the main findings of the study, discussed in the following three chapters. It is important to note that the information presented here is based entirely on data collected in the interviews. No further information was available about the young people apart from what they themselves shared in the interview.

3.2 The young people who took part in this study were a very diverse group with a wide range of backgrounds and experiences. Their lives were complex, and sometimes chaotic. Despite the many differences between them, there were also some striking similarities as well.

### **Chronology of self-harm / attempted suicide**

3.3 All the young people who took part in this study had self-harmed for many years. The mean age at which self-harming began was 12.5 (median = 12.0). The mean age of first suicide attempt was 16.2 (median = 17.0). Table 2.3 on the following page shows, for each individual, the relationship between the age of starting self-harming and age of first attempted suicide. In general, the young people had self-harmed for a number of years before their first suicide attempt. Two had attempted suicide at the same age at which they began self-harming. However, four only began self-harming *after* their first suicide attempt.

3.4 Interviewees commonly had made more than one suicide attempt. Eight had attempted suicide on more than three occasions. Four individuals were unable to say how many times they had attempted suicide, as they had made so many attempts. Moreover, all interviewees spoke of suicidal feelings and impulses over a number of years which had not been acted on.

### **Family / home life**

3.5 In general, the young people in this study had very difficult family lives. Fewer than half lived in intact two-parent families, and even among those that did, there were reports of serious difficulties with relationships with one or both parents during their adolescent years. Some said they had a good relationship with one parent (but not the other), or with a sibling, but it was uncommon for the interviewees to describe their relationships with their parents as “good” or supportive. Difficult relationships with mothers, stepfathers or mothers’ partners provided the impetus for several interviewees to move out of the family home at age 16 or 17.

3.6 A common theme running through many of the interviews was one of physical and/or sexual abuse, neglect and emotional cruelty within families. About half of the interviewees said that one or both of their parents had had serious mental health problems, and in three cases, the young person had had to care for a mother and / or siblings because of a mother’s mental health problems. Three individuals had mothers who had themselves attempted suicide on one or more occasions. Several had also grown up in households where one or both parents misused alcohol, and one individual had been taken into care at least partly because of a mother’s drug problem.

**Table 2.3: Age of first self-harming and age of first attempted suicide**

	Age of first self-harming	Age of first attempted suicide	Number of years between starting to self-harm and first suicide attempt
Young men	10	21	11
	11	12	1
	12	17	5
	12	11 (before self-harming)	—
	14	19	5
	15	17	2
	16	19	3
	Unclear (after suicide attempt)	15	—
Young women	5	16	11
	10	14	4
	11	13	2
	12	17	5
	12	12	0
	12	20	8
	Unclear (after suicide attempt)	13	—
	14	17	3
	15	12 (before self-harming)	—
	16	19	3
	17	17	0
	17	18	1

3.7 Difficult relationships with mothers was raised as a significant issue by about half of the young people — both young women and young men. Many spoke with real anger and bitterness about what they perceived to be a lack of support, abandonment, rejection and even betrayal, by their mothers at different stages in their lives. Even among young women who had been sexually abused by male relatives or male friends of the family — their greatest anger was often directed not at the person who had abused them, but rather at their mothers who refused to believe them, or who, despite believing them, had provided no support.

3.8 However, there were some exceptions to this generally bleak picture of young people's family lives. Not all of the young people who participated in this study had experienced abuse or neglect at home. However, most grew up in families that were under pressure in some way. These pressures came from a variety of sources, including: parental mental health problems and substance misuse, chronic physical health problems among siblings or among the interviewees themselves, parental separation and divorce and financial difficulties.

3.9 In some cases, interviewees who had received counselling or other psychological interventions in recent years, were able to reflect back on how their own behaviour may have contributed to pressures in their family. A minority admitted to engaging in risky or reckless behaviour (through drug or alcohol use) during their adolescent years, or having difficulties in controlling or dealing appropriately with their anger.

3.10 However, a pervasive theme in the interviews with these young people, whatever their family circumstances, was a general feeling that they were unable to be completely open and

honest with their parents about their own problems – either because they did not believe their parents would respond helpfully, or because they did not want to burden their parents further.

### **Living arrangements and experiences of homelessness**

3.11 At the time of interview, only two of the young people in this study were currently living with one or both of their parents. One of these had returned to the family home after having been away for a number of years to attend university. Both of these individuals reported having good relationships with their parents.

3.12 Eleven out of the 20 young people in this study had experienced homelessness at some point in their lives and at least five were living in homeless accommodation or supported tenancies at the time of the interview. The most common reason for becoming homeless was that the young person left home following a serious argument with a parent, or a mother's partner, and had nowhere to go. In general, they were aged 16-18 at the time.

### **Experience of education and employment**

3.13 The young people in this study generally reported not very positive experiences of school. Bullying and / or social and academic pressures at school were seen by several to have had played a key part in their reasons for starting (and continuing) to self-harm. The requirement to participate in physical education classes at school was cited as a particular trial for some of the young people. In some cases, this might be because of a lack of fitness (which resulted in further bullying), or because of a fear that the marks and scars of their self-harm would be noticed and commented upon. Two young people had experience of being referred to the Children's Reporter for not attending school.

3.14 Six young people had attended some university, but five of these had to leave their course early either because of their self-harming or because of depression more generally.

3.15 At the time of the interview, several of the young people were enrolled in college courses. Roughly half of the young people in the study were in (either full-time or part-time) paid employment. Two had never worked, and two others reported that they had only one or two experiences of paid work which lasted no more than a few weeks. Two of the young women were full-time mums who were not in paid employment at the time of the study.

3.16 Young people's experiences of work or worklessness were not explored in detail. However, straightforward experiences of work appeared to be unusual. It was more common for short periods of work to be interrupted by long periods of mental ill health. Moreover, it would seem that none of the individuals in this study returned to the same job or course of study they had been in prior to going off sick. For some, their experiences of training, employment or voluntary work were clearly positive and gave them a sense of personal satisfaction and fulfilment. For others, work was seen as just another source of stress in their lives, and one with which they had difficulty coping.

3.17 Experiences of volunteering (often undertaken with the aim of getting practical work experience) were generally reported as positive, often because of the high levels of support that came along with these experiences. (Chapter 7 describes one such example of this.) It was common for the young people in this study to express a desire to help other people in their work.

### **Experience of local authority care**

3.18 Just over a quarter of the young people in this study had experienced local authority care as children. Two had spent time in “children’s homes” as they called them, and both of these experienced homelessness after leaving care at age 16. One individual had been removed from her family home as a child by the local authority and placed with grandparents who themselves were physically and emotionally abusive. One young person, who was in secure accommodation at the time of the interview, had been in care for seven years.

### **Experience of the criminal justice system**

3.19 There was very little criminality reported by the young people in this study. One young man had been imprisoned at one stage for having assaulted his mother’s boyfriend. Driving offences and other minor offences were also reported by two of the young men.

3.20 Fewer than half of the young people said they had experience of using illicit drugs (usually cannabis or ecstasy). However, it was not clear whether any of these individuals had ever been arrested or cautioned for drugs-related offences.

### **Experiences of sexual assault**

3.21 Two of the young men and five of the young women who participated in this study had been raped or sexually assaulted on one or more occasions in the past. In the case of three of the young women, the abuse began when they were children. One of the young men had only recently begun to speak of his experience and seek help for the trauma — some 10 years after the incident. The other directly attributed his suicide attempt to his experience of being sexually assaulted. Neither of the young men had reported their attacker. In both cases, the individual was known to them.

3.22 Some of the young women *had* reported their attackers, and in each case, the outcome of this was nearly as traumatic as the assault itself. This was particularly so where the individual involved was a relative — i.e., a father or uncle. In these cases, the accusation made by the young woman further divided families that were already under serious strain and the young woman was made to feel that she was very much to blame — if not for the attack itself, at least for the resulting unpleasantness of the police investigation.

### **Sexuality and gender identity**

3.23 Three of the young people in this study indicated that issues to do with gender identity and / or sexuality had been among the factors which led to their self-harming. Bullying and social isolation at school had been a factor for these young people as well. Two of these individuals also reported being sexually assaulted by a male relative. Both felt that their self-harming and suicidal behaviour were very much connected to traumatic life events as well as the difficulties and pressures associated with trying to come to terms with their own sexuality.

### **Mental health status**

3.24 All but three of the participants in this study had been diagnosed with, and received treatment for, depression at some point in their lives. At the time of the interview, thirteen

individuals reported that they were still taking antidepressants — in most cases fluoxetine. However, two others — both young men — said that they had taken a decision to stop taking their antidepressants, although they thought they probably should still be taking them.

3.25 Two of the participants in this study, again both young men, had been diagnosed with bi-polar disorder. Two of the women had been diagnosed with borderline personality disorder. One other participant in this study had, at one stage been diagnosed with a schizo-affective disorder, and several described times in their lives (in some cases, still on-going) when they had been troubled by psychotic symptoms including paranoia, hallucinations and hearing voices. Four of the eight young men, and two of the women in this study had been prescribed anti-psychotic medication at different stages in their lives.

3.26 Three young people reported experiences of “dissociation” — either when they self-harmed, or during one or more of their suicide attempts.

### **Experience of services**

3.27 The young people in this study all had extensive experiences of services of one form or another. NHS services, in particular, were a major feature in the lives of these individuals, both in the past and in the present. These included: general practitioners, community mental health services, specialist hospital-based mental health services (i.e., child and adolescent mental health, psychiatry, clinical psychology), and emergency care services. The interviewees had varying experiences of these services, some positive and some extremely negative, and while some of the negative experiences were recounted from a few years ago, others were clearly more recent.

3.28 Twelve individuals had been admitted to psychiatric hospital on one or more occasions — five individuals had been admitted compulsorily under the Mental Health Act. Two of these had spent an extended period of time in a psychiatric hospital (more than six months). In all cases, experiences of compulsory treatment and detention took place prior to the introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003, the main provisions of which came into effect in October 2005.

3.29 In general, the young people in this study found their experience of psychiatric hospitals to be extremely distressing. This was particularly so for those who had been admitted and treated compulsorily. These past experiences (which, in some cases, had taken place a number of years ago) appeared to colour people’s views of psychiatric treatment now. At the same time, there was also a small minority of young people who reported more positive recent experiences of psychiatric treatment. The difference in experience between these two groups is discussed in Chapter 7.



## CHAPTER FOUR      YOUNG PEOPLE'S EXPERIENCES OF SELF-HARM AND ATTEMPTED SUICIDE

4.1 This chapter describes the young people's experiences of self-harm and attempted suicide. It looks at the methods they used to self-harm and attempt suicide, and the circumstances which led them initially to self-harm, and to attempt suicide. It also covers the reasons that young people continue to self-harm.

### Methods of self-harm

4.2 When asked what form their self-harm took, the young people in this study provided details of a large range of methods. These were:

- Self-cutting (with razors, Stanley knives, kitchen knives, glass, tops of tins)
- Self-battery (hitting oneself *with* a large heavy object, or *against* an immovable object, hitting or punching walls, head-banging)
- Overdosing (taking sufficient numbers of tablets to cause sickness, but which the individual believed were not sufficient to cause death; experimenting with different types and numbers of tablets; misusing prescribed medication)
- Burning (with cigarettes, lighter, a hot iron or using a finger nail or rough object to cause a friction burn)
- Picking / scraping / scratching skin until it bleeds
- Pulling hair
- Drug and / or alcohol misuse
- Forms of eating disorder (both starving oneself (anorexia) and overeating then deliberately making oneself sick (bulimia)).

4.3 Less common methods of self-harm included: drinking shampoo, biting oneself, using a screw to puncture the skin, and scalding oneself with boiling water.

### Methods of attempted suicide

4.4 When asked what form their suicide attempt(s) had taken, the range of methods described were considerably smaller than those used for self-harming. These were:

- Overdosing (often in combination with large quantities of alcohol)
- Hanging or self-strangulation
- Self-asphyxiation (putting a plastic bag over head)
- Jumping off a bridge or attempting to jump off a building
- Deep cutting (veins or arteries in arms or wrists)
- Deliberating crashing a car, or throwing oneself in front of a car
- Attempting to shoot oneself with an airgun.

4.5 Overdosing was by far the most common method of attempted suicide, both among young men and young women. It should be noted that most of the other forms of attempted suicide listed above were also used both by young men and young women. However, as will be seen in Chapter 6, the last two in the list above were mentioned only by young men and self-asphyxiation was used only by one individual, a young woman.

## Why young people started self-harming

4.6 All the young people in this study were asked *why* they first started self-harming. In general, their responses to this question strongly suggest that the act of self-harm, at least initially, was an impulsive response to difficult — in some cases extremely difficult — life circumstances. It did not seem to be something the young person deliberately planned or entirely understood themselves.

*I didn't really think about it. (Female, aged 18)*

*Don't know where it came from because I hadn't, you know, read about it in the newspaper, or I hadn't had friends who told me they were doing it or anything like that. I just one day picked up a knife and started cutting myself. (Female, aged 24)*

*When I was fifteen, locked in my room, instead of trying to get me into school, someone should have been trying to maybe help me deal wi' issues of self-harm, and actually recognise that that's what I was doing, because I didn't even know what I was doing at that point. (Female, aged 19)*

4.7 There were a few exceptions, however. One young man said that he started self-harming because his girlfriend at the time self-harmed, and she had told him that self-harming gives her a sense of release and makes her feel better. Shortly afterwards, he began to cut himself with pieces of glass and found that he understood what she meant. Similarly, one young woman said she got the idea for cutting herself after having seen scars on the arms of a close friend who had recently cut herself. However, in this latter case, the young women's reaction to seeing her friend's scars was not sympathetic:

*... and I remember that I, I was really angry with her and very, not very understanding at all: "You stupid girl. How could you do such a silly thing. Don't ever do that again," and stuff like that. And a week later, I go and do the same thing and I felt very guilty about that afterwards. (Female, aged 22)*

4.8 However, the experiences of these last two individuals appeared to be unusual. It was more common for the young people in this study to say that they hadn't known anyone else who self-harmed before they themselves started self-harming.

4.9 In describing the circumstances in their lives that first prompted them to self-harm, a number of things were mentioned over and over again — often in combination:

- Being bullied or ostracised at school
- Being abused or neglected at home
- Having a serious argument with parents or friends.

4.10 In addition to these external circumstances, young people explained their reasons for starting to self-harm in terms of how they *felt* at the time:

- Feeling pressured by school work
- Feeling misunderstood, hated or abandoned by parents
- Feeling out of control
- Feeling overwhelmingly frustrated and angry
- Feeling lonely or isolated

- Feeling down / depressed / worthless.

4.11 Again, it was often the case that a single individual reported more than one of these feelings.

### **Reasons for continuing to self-harm**

4.12 Young people explained their reasons for continuing to self-harm as:

- A way of getting relief from mental / emotional pressure or pain
- A way of coping with difficult circumstances or the pressures of life
- A way of escaping or taking a break from difficult circumstances or feelings
- A way of making themselves feel alive when they felt “numb”, “dead” or “empty”
- A way of letting off steam, expressing or dealing with overwhelming anger or frustration
- A way of punishing themselves (because they didn’t like themselves or because they felt bad about themselves)
- A way of having control over something.

4.13 Young people’s perspectives on their self-harm varied. Some said that self-harming made them feel “better”, “calm”, “chilled out”, “clean”. Others said it helped them to think clearly again, that it brought them “back to planet earth”, that it took a weight off their shoulders, that it helped them feel integrated or at one with themselves again.

4.14 Several said that the physical pain that resulted when they hurt themselves provided a helpful distraction from the mental pain they were feeling. Some said that they felt tired or exhausted after self-harming.

4.15 However, others — while acknowledging that self-harming made them feel better, at least for a little while — also admitted that they felt regret, guilt, shame and anger with themselves after they self-harmed.

4.16 Some also suggested that, for them, there were times in their lives when they considered their self-harming to be “a cry for help.” These tended to be individuals who used overdosing as a method of self-harm and who had been hospitalised following an overdose. However, this view was also expressed by two individuals whose self-harming had involved cutting, anorexia / bulimia and drug use.

4.17 In contrast, one individual specifically said that, for her, self-harming *was not* a cry for help:

*I know people say, like, self-harming can sometimes — it’s a cry for help, but, like, I don’t really see it as that. Because if it was a cry for help, then people would go and tell everybody, if you get what I mean. Because then that’s the only way they’re going to know, but like, most people who self-harm **need** it, if you get what I mean. (Female, aged 18)*

4.18 Several young people described their self-harming as a kind of addiction — something that they *needed* to do. Others echoed this view without stating it explicitly, for example, in explaining why their self-harming had become more frequent or more dangerous at different times in their lives:

*So, it [cutting] did give me some sense of relief, but after a while, that's why I moved onto other things. Because it wasn't enough by that time. So I started, well, things which were probably a bit more dangerous. (Female, aged 23)*

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*Researcher: Do you have any idea why it [your self-harming] got worse?*

*Interviewee: Because I think the rush wasn't enough. I think originally, just that tiny bit was enough, but it's like, you want more and more of a rush. (Male, aged 21)*

4.19 It is worth noting that several individuals also reported that they had stopped self-harming altogether at certain times in their lives. For example, one young woman said she had not self-harmed during the whole time she was pregnant. A young man said his self-harming stopped for a while when he began attending a local young person's drop-in service and met his girlfriend. This issue was not explored in detail, although examples came up in several interviews. These comments suggested that certain circumstances in young people's lives gave them a greater sense of well-being which made self-harm unnecessary.

### **The 'hidden' nature of self-harm**

4.20 In general, the participants in this study had self-harmed for some time before anyone else became aware of it. These discoveries sometimes happened when the young person had to be taken to hospital for emergency treatment following an overdose or an episode of cutting for which they could not stop the bleeding themselves.

4.21 However, interviewees also commented that their parents had, in fact, been aware for many years that they were often ill, or always hurting themselves, but the illnesses were always assumed to have a natural cause, and injuries were always assumed to be accidental, rather than self-inflicted. The young person was considered to be clumsy or accident-prone. One young woman who suffered from anorexia for years, said that her parents had taken her to doctors about her weight loss and vomiting, but since she never admitted to anyone that she was making herself sick, the anorexia was not diagnosed until years later, by which point she was very ill indeed. Similarly, another young woman who regularly self-harmed through overdosing said that she was often ill following overdoses, but her mother never realised the true cause of these illnesses.

4.22 Although some young people attempted to hide the marks, bruises and scars of their self-harming, others appeared to have made less effort to do so. It seems it was not at all unusual for other people to notice these things and ask about them. However, young people made the point that even when parents, friends or classmates directly asked them how they had cut or injured themselves, a false explanation always seemed to be enough to satisfy and stop any further inquiry. It appeared to be rare for anyone to recognise the signs of self-harm for what they were, and to offer the young person help or support. Two examples were given:

*The first one who noticed anything was my tutor at the college. He was a former navy chef that went into social work and then became a trainer afterwards. So he had seen it all pretty much. And he knew something was up. And I could get on with him because, for all he was thirty or forty years older than me, he was a brilliant laugh. Well he noticed something was wrong with me for a while, for*

*about a week. He says, "I've been watching you for the last week there. You've not been right a' week and I was wondering what's up." And I was like, "I'm fine," because I thought I was acting fine, but obviously he'd noticed stuff that I wasnae hiding. And he found out about my self-harming half way through the next week. I think there were scars, there was a mark on my arm somewhere that had become visible somehow, and he'd noticed it, and said something. And all I remember him saying was like, "I don't know why you're daein it, but if you're going tae dae that, be careful, dinnae be using anything too sharp, try no' tae run too deep," he says. I was quite embarrassed after that. (Male, aged 22)*

*I'd a cut on my wrist, and people started talking in my class about it and they brung it up to my guidance lecturer and my lecturer had a talk to me about it. And she basically said, do you want to see the college counsellor? And I said, yes, OK. (Male, aged 20)*

4.23 The young people themselves seldom told anyone else of their self-harming and nearly all took pains to hide the *act*, if not the *results* of self-harm. There were a few exceptions to this general rule (where the young person injured him/herself in the presence of other people), but this seemed to be a very uncommon occurrence even for the person who recounted the incident. And in cases where the act of self-harm was witnessed, young people had the impression that the person who saw it still did not always understand what they were seeing, or the implications of it:

*I think sometimes if I got really upset, I'd do things in front of her [mother], but it was never things that were really, really extreme, sort of. I'd just bang my head off something or something like that. And she never really, never thought about getting any help for me or anything. I think she just thought I was a teenager going through a kind of hard time. (Female, aged 24)*

*I went home and into my room and went scripto<sup>8</sup> because I missed this bus. I was so angry. I was like, I was crying, I was so upset. And I went into the bathroom and I started punching the toilet and sink so hard my knuckles started to go all red and bruised. And then I just snapped again. I went quiet, and my mum's like, she didn't think there was anything wrong wi' me after that, she thought I had just calmed doon. But what I did was, I went doon into the kitchen and I boiled the kettle and I just, I was a' numb at this time. I didnae – it was like I was sleepwalking, it's like I black out, but I don't, because I still know what I'm doing. I just went completely silent, boiled the kettle, held my hand over the sink and poured the kettle all over my hand. And my mum walked up behind me and went, 'Oh, you're making tea.' She didn't even know what I was doing, right, and I still continued to pour it over my arm like, just facing oot the window. (Female, aged 19)*

4.24 If the young person *did* tell anyone about their self-harm, it tended to be friends (often boyfriends or girlfriends) or partners. Few attempted to tell a GP, teacher or other professional — and those that did often got mixed reactions. One young woman, who grew up in an abusive home, recounted how her self-harm was discovered by a teacher at school.

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<sup>8</sup> “went scripto” – was furiously angry.

And when she told the teacher that she had been hurting herself, the whole matter was taken out of her hands.

*Interviewee: No one noticed [the self-harming] until I was at school and we had to do swimming and then one of the teachers noticed it.*

*Researcher: What did the teacher say?*

*Interviewee: She took me aside and asked what I'd been doing, and I just told her I wanted to hurt myself, which ended up with the headmaster phoning a psychiatrist and then \*\*\* [her mother] finding out which was a lot worse. (Female, aged 20)*

When this same young woman broke down in tears at school sometime later because of persistent bullying, she told her deputy headmistress about the abusive situation at home — at which point, the social work department was called in and she was taken into care. She attempted suicide for the first time shortly afterwards.

### **Young people's understanding of self-harm**

4.25 Young people in this study who were in the process of trying to move on from years of self-harming often said that it was only through counselling that they had come to recognise and understand that certain aspects of their behaviour when they were younger were, in fact, subconscious — rather than deliberate — forms of self-harm. Hazardous drinking, drug-taking, anorexia and bulimia were all given as examples. In the individuals who had experience of these behaviours, these were simply one method of self-harm among a range of others. However, these behaviours were not recognised by the young person as 'self-harm' until a later stage in their lives. And indeed, other interviewees did not consider their drug and / or alcohol misuse to be forms of self-harm at all. This is interesting since young people tended to describe their reasons for engaging in these behaviours in the same words they used to describe their reasons for cutting or overdosing:

#### **Anorexia / bulimia**

- To punish themselves
- To have control over something.

#### **Drug / alcohol misuse**

- To help themselves cope
- To forget about life for a while / to block out memories
- To relax
- Because they hated themselves.

The “subconscious” aspect of self-harming was also raised by interviewees in describing other forms of self-harm:

*That was how I let off steam, was by scratching, and then at times you would do it without — the brain wouldn't think about doing it, you would just be doing that and you're not really thinking about what you're doing, you're just doing it. But there's obviously something there subconscious that's driving you towards doing it. (Male, aged 24)*

4.26 Those who used cutting as a form of self-harm reported similar experiences – at least when they first began to self-harm. The act of cutting was, at times (although certainly not always), an impulsive one – done without thinking in circumstances of extreme emotion. Young people’s recognition and understanding of their behaviour as something which could be described as ‘self-harm’ appeared to evolve over time.

### **Overdose as self-harm**

4.27 Overdosing as a form of self-harm was reported by slightly less than half the young people who participated in this study. This was generally used in addition to other methods, such as cutting or burning. Overdosing as a method of self-harm involved ingesting large quantities (and sometimes different combinations) of tablets — usually paracetamol or over-the-counter pain-killers, but also anything else that was to hand (prescribed anti-depressants, sleeping tablets, etc.). The aim was to take enough to make oneself very ill, but not enough to be fatal. Overdoses ranged in severity from those that resulted in vomiting, sickness and a few days in bed, to those which required emergency care and hospitalisation for several days. In each case, the young person was clear that the overdose was *not* a suicide attempt.

4.28 In general, those who practised overdosing as a method of self-harm said they did so because it gave them a few days rest. However, as mentioned above, it was also not unusual for young people who self-harmed through overdosing to say that, for them, repeated overdoses were a cry for help. However, one young woman made the point that this attempt at seeking help was not often well understood by hospital staff:

*But it can be difficult sometimes especially with the hospitals and that, if you go to the doctor and say you’ve taken an overdose, you need help, they think that you’re trying to attempt suicide all the time and they don’t realise that you might not have taken it for that reason. So it can be quite difficult. (Female, aged 23)*

### **Circumstances surrounding suicide attempt**

4.29 When asked about the circumstances that prompted or led to their suicide attempt(s), some young people described in detail very specific incidents. These included among other things: the unexpected break-up of a significant relationship; the remarriage, or death, of a male relative who had been sexually abusive; the death of a partner or other significant person in the young person’s life; a serious family argument; being taken into care; and being asked to leave university or college because of mental ill health. However, it was far more common for the suicide attempt to be the culmination of a long period of feeling depressed, isolated, stressed and exhausted. If a particular incident prompted the suicide attempt, it often seemed that that incident was simply one pressure too many in a life already full of pressure and unhappiness. Several young people also reported suffering from anxiety disorders including severe agoraphobia around the time of their suicide attempt. Excessive alcohol use was also frequently associated with suicide attempts.

4.30 It was very uncommon for young people to tell anyone that they were thinking of killing themselves prior to their suicide attempt(s). However, a few individuals did describe times when they told a friend, partner, support worker or NHS professional that they were feeling suicidal. This only appeared to happen for those who had made more than one suicide attempt. In every case, the first attempt was not discussed with anyone.

4.31 Young people in this group also described situations where they had not spoken to anyone *after* a failed suicide attempt. Several individuals recounted incidents where they had taken large quantities of tablets which they had expected to be fatal, but had woken up the next morning feeling extremely ill — and their parents allowed them to take the day off school because they were unwell, but otherwise had no idea of the cause of the “illness.”

4.32 However, young people also talked about “changing their minds” following an attempted suicide by overdose. In every one of these cases, the young person emphasised that they had taken what they thought to be a fatal quantity of tablets with the intention of killing themselves, and that they *did* want to die at the time. However, in waiting for the tablets to take effect, they began to question what they were doing. In these circumstances, several individuals phoned a friend or partner, a support worker or an ambulance — and were taken to hospital. Others went outside and were helped by passers-by in the street.

4.33 Others said they had not changed their minds at all, but were found — completely unexpectedly — in an unconscious or semi-conscious state by a family member or friend, who took them to hospital, and in many cases, almost certainly saved their lives.

### **Contact with services at time of first suicide attempt**

4.34 Thirteen of the young people in this study were already in contact with services at the time of their first suicide attempt. In some cases, this contact (with a GP or specialist mental health service) was related to depression. However, in others cases, the young people were in contact with housing / homelessness services, drug treatment services or social work services. Three individuals were also in contact with services because of a physical health problem at the time of their first suicide attempt.

### **Contact with hospital services following self-harm or attempted suicide**

4.35 It was common for the young people in this study to report that they had received hospital treatment following one or more suicide attempts and, occasionally, following a serious episode of self-harm. Only three individuals said they had *never* been to hospital — either following a suicide attempt or for their self-harm. For those who attended hospital following an episode of self-harm that involved cutting, treatment was generally provided by A&E, and the individual was discharged.

4.36 Those who attended A&E following a suicide attempt or an episode of self-harm involving an overdose usually received some form of psychiatric assessment. However, young people indicated that they were not always entirely honest in answering questions about their suicidal intentions — either because they felt that hospital staff were unsympathetic, judgemental, too busy to care, or simply because they didn’t know them.

*Interviewee: They made me talk to a psychiatric nurse and I kind of lied to her. She was like, ‘Did you really want to kill yourself?’ I was, like, ‘No, that was just me being stupid,’ and ‘No, I didnae really want tae kill myself.’*

*Researcher: Why did you feel you couldn’t talk to her?*

*Interviewee: I was pissed off. I didn’t know her. I didn’t trust her. (Female, aged 19)*

## CHAPTER FIVE THE LINKS BETWEEN SELF-HARM AND SUICIDE

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*For me, self-harm was like an escape and suicide's the ultimate escape. (Female, aged 18)*

*Self-harm for me was like trying to cope, but when I really couldn't cope I would try and kill myself (Female, aged 25)*

*Self-harm is about survival. You've got to want to live for it to work. When you want to die, it doesn't work. (Male, aged 21)*

*Self-harm is what I do to stop myself committing suicide. (Female, aged 24)*

*Self-harm and suicide are quite different. The only link that I would see is that when self-harm goes too far and you don't actually realise how badly you've done something. (Female, aged 23)*

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5.1 The main aim of this study was to explore the links between self-harm and suicide in young people — to answer the question how and why does self-harming behaviour become suicidal. This question was explored directly — by asking young people what they saw as the links between the two — and indirectly — by asking them about how their self-harming changed at various times in their lives, and what they considered to be the differences between self-harm and suicide. This section discusses these findings.

### **Self-harm and suicide — similar or different?**

5.2 In general, the young people in this study were able to make a very clear distinction between their self-harm and the times when they had attempted suicide. This was the case even if they used the same methods for both self-harm and suicide. (There were some exceptions and these will be discussed later in this section.) However, there was disagreement about whether self-harm and suicide were linked, or whether they were completely different.

5.3 Those who saw them as **linked** tended to see self-harm on a **scale, or continuum**, with suicide at one end.

*It's like, myself, I started off with hitting myself with things, then I started cutting and drinking, and then I jumped over the bridge. To me it goes in stages. If you don't get help to control it, then it just keeps on getting worse. (Male, aged 24)*

5.4 Another young man suggested that self-harm and suicide *may* be linked for some people, but not others, depending on why the person was self-harming. This individual felt that those who used self-harm as a “clean, clinical way to release steam” are less likely to seriously contemplate suicide, but those whose self-harm was borne out of depression, self-loathing and a sense of worthlessness, were at much higher risk of suicide.

5.5 One young woman who saw self-harm and suicide as quite different nevertheless conceded that people who self-harm and have no intention of killing themselves can end up dying accidentally. This was seen to be a particular risk for people who self-harm through overdoses of paracetamol, since repeated overdoses lowered the body's tolerance levels for paracetamol. Therefore, doses which had previously been non-fatal could one day be fatal. Anorexia was given as another example where self-harming behaviour could lead to accidental death — particularly where it was combined with other forms of self-harm such as drug or alcohol misuse.

5.6 One young man also highlighted the possibility that an overdose — intended as self-harm (i.e., “to get a few days sleep”) — could prove to be fatal. However, this individual made an entirely different point to the young woman mentioned above:

*Researcher: It sounds to me like you make quite a clear distinction between your self-harming and your suicide attempts. You said that in the times when you attempted suicide, you wanted to die in every case. But has there ever been a time where maybe you weren't sure that you wanted to die?*

*Interviewee: I find it the opposite way round. Sometimes, in cases where I just want a few days sleep, I really don't care if it ends up being the rest of my life sort of thing. (Male, aged 25)*

5.7 Other young people in this study argued that, for them, suicide was completely **different** to self-harm — and the factor which made them different was simply the **individual's intention**. For those in this group, suicide became an option when self-harming “didn't work” or when they no longer got the satisfaction from self-harm that it used to give them.

5.8 Some also pointed to differences in their behaviour which were specifically associated with their suicide attempts. For example, several individuals spoke of planning their suicide attempts very carefully. One young woman who used overdosing as a method of self-harm as well as suicide, said she cut herself off from other people and became more secretive prior to her suicide attempts.

*And I must admit, with suicide I plan it for weeks and weeks before. I think that's why I see a difference between them. Because I think about it for a long time before doing it. Quite often when I self-harm, there's other people around, like, I know that somebody's coming to the house or whatever. So if something did go wrong, I would be found. But when it's suicide, I try to cut myself off a lot more. I've noticed that, well, I'll stay on my own for days on end and not get in touch with anybody and not let anybody know where I am, or whatever. And I become quite secretive. It seems very different to me. The doctors don't notice, but to me, I do. (Female, aged 23)*

5.9 Another young woman made a similar comment, only in reverse. This individual was at a stage in her life where she was trying to control her self-harming, but she continued to have suicidal feelings. She was often able to put off her desire to self-harm, but found it more difficult to control her suicidal impulses.

*Researcher: What do you feel is the difference between your self-harming and your suicide attempts?*

*Interviewee: Often self-harm is what I do to stop myself committing suicide [laughs] Self-harm is more about relieving tension, physical or emotional, or — you know, there'll be a build up that I need to get rid of. Whereas suicide is more about wanting to die.*

*Researcher: Why is it, in those circumstances where you've wanted to die, you haven't tried to self-harm?*

*Interviewee: Sometimes I **have** tried to self-harm and it hasn't been effective. Other times, it's come on so quickly that there hasn't been time. Because I don't just go, "Oh, I think I'm going to self-harm," and then cut, you know. There's sort of a big build-up. There's often several days of wanting to do it before I actually go ahead and do it. If the suicidal feelings come on too quickly for that, then I'll skip that stage and go straight to... (Female, aged 24)*

### **Changes in self-harming behaviour before and after a suicide attempt**

5.10 A common theme which arose in many of these interviews is that the young person's self-harming behaviour often changed in significant ways just before and after a suicide attempt. Some individuals said that their self-harming became much worse — in particular, more frequent — immediately preceding a suicide attempt. Individuals spoke of feeling numb, and in many cases, the increased frequency of self-harming was an attempt to overcome this numbness and to "get something out of it." Others said that they stopped self-harming altogether — usually because "it wasn't working anymore."

5.11 Many also said that they stopped self-harming completely for a period of time immediately *after* a suicide attempt.

*A lot of the time after you've tried to commit suicide, you just sit in a blank space basically. You don't want to do anything, you just want to try to get back to normal. (Female, aged 24)*

*I didn't really cut myself that much after [his suicide attempt] because I tried to kill myself and I didn't, I didn't know how I was supposed to react to surviving. (Male, aged 22)*

*After [his last suicide attempt], I didn't do anything [self-harming] for a week or two I think. Also, another way I self-harm is, I starve myself quite a lot, but after the last time, I ate quite well for like, ridiculous logic, totally skewed, but like, I felt like I deserved it. So I ate quite well for a bit after that time. (Male, aged 21)*

### **Self-harm and suicide – the same**

5.12 As mentioned above, in general, the young people who participated in this study felt that self-harm and suicide were different. This was true even for those who had made multiple suicide attempts, and where the methods used for self-harming and attempted suicide were the same.

5.13 However, it is important to note that, for two individuals – interestingly, both young men – the distinction between the two was much less clear:

*I'd say if you're doing suicide, then you're self-harming, aren't you? If you're self-harming, then you can kill yourself. (Male, aged 14)*

*I just feel when I try to kill myself, I'm self-harming. But I don't see the difference, it's all the same, basically. (Male, aged 25)*

5.14 However, both these young men also described specific incidents in the past where they had injured themselves, where the intention had clearly *not* been to end their lives. Here is an example given by the younger of the two:

*Interviewee: I punch my wall in here all the time.*

*Researcher: Why do you do that?*

*Interviewee: I think it chills me out, man. It cracks me up a lot in here.*

*Researcher: Chills you out?*

*Interviewee: Aye, because it's painful. Sometimes things get – it chills you right out, man. Just sitting. And that's you perfect again. Apart from 20 minutes later, when you feel, "Ah!" [shakes hand, making sound of pain].*

*Researcher: When was the last time that happened?*

*Interviewee: Last night.*

*Researcher: What happened last night?*

*Interviewee: I got angry cause I wanted to kill a boy here. There's this boy here, and he's immature. Normally, people are mature cause they're our age, you know, but this wee guy... I'm telling you... I don't like him. I've already fought with him three times. (Male, aged 14)*

5.15 These two individuals appeared to have much less awareness about the whole subject of “self-harm” than many of the other young people who participated in this study. Neither appeared to recognise that certain aspects of their behaviour could be classified as “self-harm.” The fact that they occasionally injured or hurt themselves did not appear to be deliberate or conscious. Here is an example given by the older of the two:

*One time I got spiked<sup>9</sup> when I was out with friends, and I came back home and I was wondering what this feeling was – it was ecstasy – and I started slicing away at my face. (Male, aged 25)*

5.16 Given the circumstances of these two young men, this was perhaps not surprising. Both had been referred to psychiatric services following suicide attempts. Both had had experience of being compulsorily admitted, in one case, to secure accommodation, and in the other, to a psychiatric hospital, for extended periods of time. Neither had wanted these services, and in fact, neither seemed to feel they had any need of them. In the case of the 25-year-old, this was despite a diagnosis of bi-polar disorder.

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<sup>9</sup> “spiked” – someone put a drug in his drink without his knowledge.

5.17 The lack of awareness by these two young men of their self-harming behaviour, as something separate from their suicidal behaviour, echoes a point made in the previous chapter — that young people’s understanding of what constituted ‘self-harm’ evolved over time.

### **“Self-harmers know exactly how far to go” (Female, aged 19)**

5.18 In describing the differences between self-harm and suicide, there was a view expressed by interviewees that people who self-harm know very well how far they can go before their self-harm is likely to be fatal. This view was expressed among young people who cut themselves as well as those who self-harmed through overdosing.

5.19 One young woman said that she had gone through a stage of testing herself and her limits through cutting herself in different ways. Another young woman reported that over a period of two years, she routinely took overdoses about once a month. This involved taking different numbers and kinds of tablets, and mixing them in different ways. This practice often made her ill, but not so ill that she required hospitalisation. She described this period as a kind of “experiment” — to see what effect these different tablets had on her body and how much her body could take. Another young woman made a similar comment:

*I got quite savvy at knowing, you know, if I go to hospital having taken this many tablets, they’re going to want to book me in. Whereas if I go to hospital having taken **this** many tablets, they’ll just make me drink lots overnight and make me see the psychiatrist the next day. (Female, aged 24)*

5.20 However, as already highlighted above, a contrasting view was also expressed among some individuals who self-harmed through overdosing — namely that lowered tolerance levels to paracetamol over a period of time could lead to accidental fatal poisoning.

### **Overdosing as self-harm and suicide attempt**

5.21 In general, those who practised overdosing as a method of self-harm made a clear distinction between overdoses that were intended as self-harm, and those that were suicide attempts.

5.22 However, on the surface of it, irrespective of whether they intended to self-harm, or intended suicide, there appeared to be very little difference in their behaviour — both involved taking large quantities of tablets; hospitalisation was often required in both cases; and frequently, in both cases, it was they themselves who phoned an ambulance. Suicide attempts sometimes involved larger numbers of tablets, and this inevitably meant they were hospitalised for a longer period of time.

### **Cutting as self-harm and suicide attempt**

5.23 Just as overdosing was used as a method of self-harm and attempted suicide for some young people, cutting was also used both as a method of self-harm and attempted suicide by others. However, the use of cutting for suicide was less common than its use as a method of self-harm.

5.24 Moreover, in all the cases where young people had cut themselves as a suicide attempt, the intention appeared to be to cut themselves much deeper than they ordinarily would when

self-harming. One young man describing cutting himself inside his elbow so deeply that he hit an artery. A young woman said that she had cut through the tendons on both wrists which required surgery to repair them. Another young woman said that she had deliberately tried to cut a vein in her arm in one of her suicide attempts.

## **CHAPTER SIX GENDER DIFFERENCES IN SELF-HARMING AND SUICIDAL BEHAVIOUR**

6.1 The relationship between gender, suicide and self-harm in young people is complex. As discussed in Chapter 1 of this report (paragraph 1.15), previous research suggests that young women are more likely than young men to self-harm. However, published suicide statistics, both in Scotland and worldwide, clearly indicate that young men are more likely than young women to complete suicide (Platt *et al* 2007).<sup>10</sup>

6.2 At the same time, studies have shown that suicidal feelings are more common among young women than among young men and that young women are more likely than young men to attempt suicide (Beautrais 2003; Garrison *et al* 1993; Hawton *et al* 2002). The difference in suicide rates between young men and young women appears to be related to the choice of methods: young men tend to choose methods of suicide which are more violent and therefore more likely to be fatal whereas young women are more likely to attempt suicide through overdose (Beautrais 2003; Hawton 2000).

6.3 Because of these gender differences, one of the main objectives of this study was to explore and compare the experiences and perspectives of young men and young women.

6.4 In order to do this, the original plan for this study was to interview an equal number of young men and young women. All interviewees were to be recruited through a single agency, Penumbra, which provides self-harm support services in six different locations across Scotland. One of the early findings of the study was that the Penumbra self-harm services did not have a sufficient pool of young men who could be approached to participate.

6.5 The reasons for this may simply be a reflection of gender differences in the prevalence of self-harm: perhaps young men are not to be found in self-harm support services because young men are less likely than young women to self-harm. However, there are also some alternative explanations, and these will be considered in the final chapter (Discussion and Implications) in light of the interview data gathered from young people in this study.

6.6 This section will explore some of the similarities and differences between the 8 young men and 12 young women who took part in this research.

### **Differences between the young men and young women in this study**

6.7 There did not appear to be major differences in the life circumstances of the young men and young women who participated in this study. Both generally reported multiple serious problems and stressful life events. Family problems were an important issue for both, and young men were as likely as young women to report difficult or problematic relationships with their mothers in particular. Both young men and young women in this study had experienced homelessness.

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<sup>10</sup> The only exception appears to be in rural China, where women are more likely than men to complete suicide. For information on international suicide statistics, see the World Health Organisation's Suicide Prevention website (SUPRE) – in particular, the country reports and charts available at: [http://www.who.int/mental\\_health/prevention/suicide/country\\_reports/en/index.html](http://www.who.int/mental_health/prevention/suicide/country_reports/en/index.html).

6.8 More young women than young men in this group had been victims of sexual assault or abuse as children or young adolescents, although two of the eight young men in this sample also reported that they had been sexually assaulted.

6.9 Both young men and young women reported negative experiences of school – either because of bullying or because of academic pressures. More young women than young men in this group had attended some university, although in every case, the young women also had had to leave university early because of problems with self-harm or depression.

6.10 Two of the young women had been diagnosed with borderline personality disorder whereas two of the young men had been diagnosed with bi-polar disorder. Two other young men and two other young women had been prescribed anti-psychotic medication at different points in their lives to relieve symptoms such as hallucinations, hearing voices or paranoia.

6.11 It was not unusual for the young men in this study to have experienced fights or getting into trouble with the police. One young man had been imprisoned for assaulting his mother's boyfriend; another said that he had once had a fist fight with his mother's partner. Another individual had been hospitalised after being stabbed in a fight. This latter young man had also been expelled from school on at least one occasion for fighting. None of the young women described experiences of fighting, although one young woman said that she had had difficulties in dealing with her anger.

6.12 Only about a quarter of the young people in this study of either sex reported a history of illicit drug use. Three of the young women and one of the young men saw their drug taking as a form of self-harm. Two others — one young man and one young woman — did not.

6.13 Regular excessive drinking was mentioned both by young men and young women. However, when asked directly whether alcohol played a part in their self-harming, only a few individuals of either sex said that they considered their use of alcohol to be a form of self-harm. Fewer still said that they ever used alcohol when self-harming (for example, when cutting). However, alcohol appeared to play a major role in the suicide attempts for young people of both sexes. In particular, it was common for those who attempted suicide through overdoses to report they drank excessive amounts of alcohol at the same time. One young woman suggested she needed the alcohol to overcome her fear of taking an overdose. In some cases, it seemed that the aim was to drink until they passed out. One young man jumped off a bridge following a particularly heavy drinking session with a friend, and another said that he attempted suicide by badly cutting his arms when he was drunk.

### **Differences in young men and women's experiences of self-harm and attempted suicide**

6.14 Tables 6.1 and 6.2 show the different methods of self-harm and attempted suicide used by young men and women in this study.

6.15 All twelve of the young women, and six of the eight young men had attempted suicide on at least one occasion by taking an overdose. However, fewer young men than young women used overdosing as a method of self-harm. In addition, young men appeared to be less likely than young women to have made multiple suicide attempts through overdosing.

6.16 Both young men and young women who reported attempting suicide through overdose also said that there were times when they had changed their minds after an overdose and phoned for help. Equally, both also recounted experiences where they had attempted suicide

through an overdose and had *not* changed their minds, but were found by a friend, or they woke up the next day, unexpectedly, feeling very ill.

6.17 Five of the eight young men in this study chose violent methods to attempt suicide, including hanging, driving a car off the road, jumping off a bridge, attempting to shoot himself, and jumping in front of a car / bus. Three of the young women in this study also chose violent methods including hanging and jumping out of a window.

### **Differences in young men and young women’s perspectives on the links between self-harm and suicide**

6.18 As reported in the previous chapter, the young people in this study generally made a very clear distinction between their self-harm and their suicide attempts. The only disagreement to this view came from two young men (see again paragraphs 5.13-5.15).

**Table 6.1: Reported methods of self-harm and attempted suicide among young men**

	<b>Self-harm</b>	<b>Suicide attempt*</b>
1	<ul style="list-style-type: none"> <li>• Scratching / clawing skin until it bleeds</li> </ul>	<ul style="list-style-type: none"> <li>• Overdose (1)</li> </ul>
2	<ul style="list-style-type: none"> <li>• Cutting</li> </ul>	<ul style="list-style-type: none"> <li>• Deep cutting + alcohol</li> <li>• Hanging</li> <li>• Starving self</li> <li>• Car accident (deliberately drove car off the road)</li> </ul>
3	<ul style="list-style-type: none"> <li>• Cutting</li> <li>• Drug and alcohol misuse</li> </ul>	<ul style="list-style-type: none"> <li>• Hanging</li> <li>• Overdose (1)</li> </ul>
4	<ul style="list-style-type: none"> <li>• Picking at skin</li> <li>• Head-banging</li> <li>• Cutting</li> <li>• Burning self</li> <li>• Overdosing</li> </ul>	<ul style="list-style-type: none"> <li>• Multiple overdoses (+ alcohol)</li> </ul>
5	<ul style="list-style-type: none"> <li>• Bruising self</li> <li>• Cutting</li> <li>• Alcohol misuse</li> </ul>	<ul style="list-style-type: none"> <li>• Jumped off a bridge + alcohol</li> </ul>
6	<ul style="list-style-type: none"> <li>• Cutting (with glass / knife)</li> <li>• Drank shampoo</li> </ul>	<ul style="list-style-type: none"> <li>• Tried to shoot self with an airgun</li> <li>• Overdose (1)</li> </ul>
7	<ul style="list-style-type: none"> <li>• Cutting</li> <li>• Punching walls and other objects</li> </ul>	<ul style="list-style-type: none"> <li>• Overdoses (unclear how many)</li> <li>• Tried to throw self in front of a bus / car / off a bridge</li> </ul>
8	<ul style="list-style-type: none"> <li>• Biting self</li> <li>• Hitting / bruising self</li> <li>• Scraping hand against a wall</li> <li>• Punching walls</li> <li>• Cutting</li> <li>• Starving self</li> </ul>	<ul style="list-style-type: none"> <li>• Slit wrists</li> <li>• Overdoses (+ slit wrists) (2)</li> </ul>

\* Where a number is shown in brackets, it indicates the number of overdose suicide attempts made by the individual. Some had attempted suicide through overdose so many times, they had lost count. These are referred to as “multiple overdoses.”

**Table 6.2: Reported methods of self-harm and attempted suicide among young women**

	<b>Self-harm</b>	<b>Suicide attempt*</b>
1	<ul style="list-style-type: none"> <li>• Scratching self with scissors</li> <li>• Cutting with razor blades</li> <li>• Overdosing</li> </ul>	<ul style="list-style-type: none"> <li>• Overdoses (2)</li> </ul>
2	<ul style="list-style-type: none"> <li>• Overdosing</li> <li>• Cutting</li> <li>• Burning self</li> <li>• Pulling hair out</li> <li>• “Getting into difficult situations”</li> </ul>	<ul style="list-style-type: none"> <li>• Overdoses (4) + alcohol</li> <li>• Cut vein</li> <li>• Self-strangulation (with elastic)</li> <li>• Hanging</li> </ul>
3	<ul style="list-style-type: none"> <li>• Cutting</li> <li>• Head banging</li> <li>• Burning self</li> <li>• Punching walls</li> <li>• Overdosing</li> </ul>	<ul style="list-style-type: none"> <li>• Multiple overdoses + alcohol</li> </ul>
4	<ul style="list-style-type: none"> <li>• Cutting</li> <li>• Scratching self</li> <li>• Overdosing</li> </ul>	<ul style="list-style-type: none"> <li>• Multiple overdoses</li> </ul>
5	<ul style="list-style-type: none"> <li>• Head banging</li> <li>• Friction burning</li> <li>• Cutting</li> <li>• Pulling hair out</li> </ul>	<ul style="list-style-type: none"> <li>• Overdoses (4 or 5)</li> </ul>
6	<ul style="list-style-type: none"> <li>• Cutting</li> <li>• Punching walls</li> </ul>	<ul style="list-style-type: none"> <li>• Overdose (1)</li> </ul>
7	<ul style="list-style-type: none"> <li>• Cutting (with razor blade / scissors)</li> <li>• Burning self</li> </ul>	<ul style="list-style-type: none"> <li>• Slashed wrists with knife</li> <li>• Attempted to jump out of a window</li> <li>• Multiple overdoses</li> </ul>
8	<ul style="list-style-type: none"> <li>• Slashing arms with knife</li> <li>• Scraping skin</li> <li>• Punching walls / other objects</li> <li>• Bruising self</li> <li>• Scalding self</li> </ul>	<ul style="list-style-type: none"> <li>• Attempted to jump out of a window</li> <li>• Self-asphyxiation (plastic bag over head)</li> <li>• Hanging</li> <li>• Overdose (1)</li> </ul>
9	<ul style="list-style-type: none"> <li>• Cutting</li> <li>• Overdosing</li> <li>• Drug and alcohol misuse</li> </ul>	<ul style="list-style-type: none"> <li>• Cut wrists and tendons</li> <li>• Overdose (1)</li> </ul>
10	<ul style="list-style-type: none"> <li>• Drug and alcohol misuse</li> <li>• Bulimia</li> <li>• Cutting</li> <li>• Overdosing</li> </ul>	<ul style="list-style-type: none"> <li>• Multiple overdoses + alcohol</li> </ul>
11	<ul style="list-style-type: none"> <li>• Cutting</li> <li>• Picking at skin</li> <li>• Anorexia</li> <li>• Drug misuse</li> </ul>	<ul style="list-style-type: none"> <li>• Overdoses (2) (1 including alcohol)</li> </ul>
12	<ul style="list-style-type: none"> <li>• Piercing skin with a sharp object</li> <li>• Cutting (with knife and razor)</li> <li>• Burning self</li> </ul>	<ul style="list-style-type: none"> <li>• Overdose (1)</li> </ul>

\* Where a number is shown in brackets, it indicates the number of overdose suicide attempts made by the individual. Some had attempted suicide through overdose so many times, they had lost count. These are referred to as “multiple overdoses.”

## CHAPTER SEVEN HELPFUL AND UNHELPFUL THINGS

7.1 One of the aims of this study was to identify issues which may be relevant to policy and service provision. To do this, all the young people who participated in this study were asked about the things, people, activities and services that had been helpful to them over the years, and those which had been unhelpful. They were also asked what they thought could be done in the future to prevent suicide among young people who self-harm. An analysis of their responses to these questions is provided below.

7.2 It is important to note that the young people who participated in this study were recounting experiences of services that took place over a number of years – in some cases, spanning more than 10 years. In cases where young people described very negative experiences of services, it is possible that these services have changed significantly in the intervening years. On the other hand, more recent experiences of services were also described, which clearly indicate that there is still some scope for improvement.

7.3 It is also important to note that the very things which may have been helpful to one person, were also mentioned by others as being extremely unhelpful. For example, some young people said that one or both of their parents had been very supportive at different stages in their lives. For others, relationships with parents were, and continued to be, extremely difficult. Similarly, some young people said that they had a very positive experience of psychiatrists, but others specifically identified psychiatrists as unhelpful and insensitive. For this reason, young people were also asked *how and why* certain individuals, services or activities had been helpful or unhelpful to them.

7.4 In discussing the question of helpful and unhelpful things, young people's responses included a very wide range of subjects. In general, these can be grouped into the following categories (in no particular order of importance):

- Friends and social networks
- Services
- Medication
- Parents
- Self-help
- Creative outlets (writing, painting, singing, etc.)
- Talking

### Friends and social networks

7.5 Young people cited examples of supportive relationships with friends, partners / spouses, employers and work colleagues. One young woman told this story about a former employer and her work colleagues.

*Interviewee: She [the boss] gave me something that would challenge me but she would also be really supportive and that. She wouldn't just leave me to do as I want and she was like, 'OK you try and do this, but if you need help I'm there.' I was working with another person in the office so it was like, he would help me too, and after a while some of the staff got told about my problems and how they could help me. And we came up with a system, and it was like traffic lights and you put different coloured circles on the wall and it tells everyone how you're*

*doing. Green means you're OK. Amber means you're kind of not too good and red means just stay away from me. And it was like, when I put the red one up, they're like, 'Oh, watch out!' [Laughs]*

*Researcher: So how often was the red one up and how often was the green one up?*

*Interviewee: The red was up more often than the green. Like, when the red one came up, they would make me loads of hot chocolate and tea and everything, and they would give me easy stuff to do. (Female, aged 25)*

7.6 Some also found it particularly helpful to meet other young people who self-harm and hear about their experiences. One individual said that attending a self-harm support group helped her to better understand how her own self-harming behaviour affects other people, and this was important in helping her to reduce the frequency of her self-harming. Some young women said that being challenged about their self-harming by a caring or concerned boyfriend or partner had the same effect, and was instrumental in getting them to find other ways of coping with their feelings. Other individuals said that good friends had literally saved their lives.

7.7 While some young people said that their friends had been very helpful, others appeared to have few friends that they could rely on, and indeed reported feeling betrayed by friends whom they trusted. One young woman said that after having split up with a boyfriend, he then went round telling everyone "what a freak and weirdo she was" because she self-harmed. Another said that she found it impossible to talk to her friends about her suicidal feelings because they just kept telling her to cheer up.

7.8 As has already been mentioned, bullying was a major feature in the lives of many of these young people during their years in school. Again, this was something that they found extremely difficult to talk to anyone about, as they assumed that talking to a teacher or parent about it would just make matters worse.

## **Services**

### ***Non-NHS services***

7.9 As already mentioned, the young people in this study generally had a great deal of experience of services. Those which seemed to be consistently helpful included private sector (one-to-one or family) counselling services and a wide range of services in the voluntary sector. Voluntary sector agencies which provided housing, employability and mental health support were frequently cited as being especially helpful. Local drop-in centres (where an appointment was not required) were also highly valued by the young people in this study. In most cases, these services were specifically targeted at young people. However, there were also a few mentioned where the service appeared to cater for people of all ages. One young woman described a voluntary sector drop-in service she had attended regularly for 10 years as "a lifeline: they're here when I need them."

7.10 Several young people named project workers in specific voluntary sector agencies whom they said had been especially helpful to them. Some of the characteristics of helpful project workers included:

- Being a good listener / making the time to listen / “finding out what makes you tick”
- Being accessible / available whenever the young person feels they need to talk
- Having (or at least *seeming to have had*) similar experiences to the young person
- Able to be trusted (in particular in relation to confidentiality)
- Being non-judgemental about the young person’s self-harm.

7.11 In contrast to these generally positive experiences with services, the experience of being homeless and living in hostels or other temporary accommodation was seen as very unhelpful. Those who had experience of homelessness generally said that their self-harming had become worse during that time.

### ***Telephone help-lines***

7.12 All of the young people in this study were asked if they had ever used a telephone help-line. In general, the answer was no, and in fact, some said they had never considered doing so — partly because they didn’t think they would feel comfortable speaking to a stranger over the telephone.

7.13 Among those who had experience of using telephone help-lines, those who had phoned Breathing Space, the phone-line service for people experiencing low mood or depression, said they would not do so again. One young woman felt the person she had spoken to “talked down” to her. Another said she tried phoning Breathing Space several times but always got an engaged signal.

7.14 Others had phoned the Samaritans and had mixed experiences. While some said they had found the Samaritans phone-line very helpful, one young person commented that, “It depends on who you get.” One individual said when she phoned Samaritans on one occasion, she felt unhappy that the counsellor had asked if they could say a prayer for her. Another young woman phoned the Samaritans at a point when she was feeling suicidal, but found it very difficult to talk about how she was feeling. At the same time, she felt pressured to say *something* because of the long silences on the telephone. This individual found the Samaritans email support service to be much more suited to her needs. This view was echoed by one of the young men who said he had used the Samaritans email service on several occasions.

7.15 One young woman found the Hearing Voices phone-line to be very helpful.

### ***NHS services***

7.16 Young people said that specific doctors (including GPs and psychiatrists), psychologists and nurses (mainly community psychiatric nurses) had been very helpful to them. However, others reported very negative and even distressing experiences of the NHS and NHS staff. Helpful NHS staff were considered by young people to have the following qualities:

- **Maintained confidentiality:** One young woman said she got on very well with her psychiatrist because the psychiatrist was there for *her*, and had nothing to do with anyone else in her family.
- **Considered the young person to be competent in making decisions about their own treatment:** Young people told of psychiatrists and psychologists who had

consulted them about medication and therapeutic interventions and then made adjustments to the young person's treatment on the basis of what the young person said to them.

- **Responsive:** Interestingly, young people in the north of Scotland recounted experiences of being admitted to in-patient facilities during crises, almost as a form of respite. One young woman said that when she felt suicidal, she would speak to her psychiatrist or CPN and arrange to be voluntarily admitted for a few days to the local hospital psychiatric ward until she felt more stable.
- **Accessible:** Individuals reported receiving a great deal of helpful support from their local out-of-hours community psychiatric nursing service.
- **Supportive:** Young people gave examples of GPs who were helpful, supportive and willing to listen — regardless of how long it took. One young man, with a particularly complex medical history, said he was especially grateful to his GP for her persistence in helping him to find the right sort of help for his severe depression. Another young woman commented on the willingness of her GP to make the time to listen:

*About six months I was off my medication and I went back to my GP last week. I was really ill and he thought it would be a good idea to go back on my medication. Because I was getting a bit flat and just no' been very happy lately, so I'm back on. But he's really, he's one of the best GPs I've ever had, he's really so, so nice. I was in there for forty-five minutes. Sitting yakking away about everything. (Female, aged 23)*

7.17 In general, the young people in this study had relatively positive experiences with *community* psychiatric nurses, but less positive experiences with hospital nursing staff. The difference may be one of relationship. Several individuals in this study had CPNs who visited them regularly and who had known them over a significant length of time, whereas many felt that hospital nursing staff didn't know them, and so could not be trusted. Others said they felt that the hospital nursing staff were judgemental or too busy to really care.

7.18 The process of receiving a psychiatric assessment in hospital following an episode of self-harm or a suicide attempt was also generally uncomfortable for these young people. Even among those who knew they needed help —and who *wanted* help — the requirement to talk to a hospital nurse or doctor whom they did not know, and who “was just doing their job”, meant that young people were not always entirely open and honest in their responses to questions.

7.19 About half of the young people in this group had been referred at one point to a clinical psychologist. These experiences generally appeared to be positive, although there were also some exceptions highlighted where the psychologist seemed to have their own theories about what was ‘wrong’ with the young person, which the young person him/herself clearly did not agree with.

7.20 As mentioned above, the young people in this study had also had some very negative experiences with NHS psychiatric services. Being compulsorily admitted to an adult

psychiatric ward was among the worst of these.<sup>11</sup> But even among those who had never been sectioned, it would seem that psychiatric hospitals were generally not considered to be very helpful. The young people in this study described their stays in psychiatric hospital as:

- Feeling trapped
- Scary
- One of the worst things
- Totally the wrong place to be
- Being treated like shite
- A nightmare
- One experience they didn't want to go through again
- Being treated like a child.

7.21 One young woman said she had discharged herself from a psychiatric ward on one occasion because she was being beaten up by other patients. Another said the experience of being admitted to an adult psychiatric ward at the age of 15 was frightening. Young people found it particularly distressing that they were not permitted to self-harm when in hospital. ("It's like removing the valve from the pressure cooker.") At the same time, it seemed they were often given nothing else to do. Others spoke of being given drugs which completely immobilised them.

*I had nothing to do. I had naewhere tae go apart frae to go and look oot a window. I wasnae – I didnae even get a bit o' fresh air for eight months. And you'd nae way o' releasing anger. There wasnae somewhere you could go and punch the hell oot o' something, you ken. There was just nothin'. (Female, aged 23)*

*We're all basically dosed up to the eyeballs. I felt like I was in a room with zombies, basically. It didn't look any of them were getting any help. I think some of them will still be there. (Male, aged 25)*

*The mad thing is I was in the hospital and they had me on these mad tablets that were for schizophrenia patients because they didnae ken what was going on, eh, they just gave us these tablets straight away and said, 'Take these and that's what the specialist said,' know what I mean? I couldnae move about very easily like, because I was, I was that wrecked. And it was like I was sitting there and I feel like I've just spent two days withoot sleep, smoking a' the time, but I didnae, if you ken what I mean. I was like sitting like that and I was like asleep, but I was wide awake, just my body was immobilised because o' the tablets and they were supposed tae, they were supposed tae ease these symptoms I was having, but they just immobilised me rather than [inaudible] and they took us off them eventually. (Male, aged 22)*

7.22 The last young man quoted above said that it was partly his fear of ending up back in hospital that kept him going when he felt suicidal.

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<sup>11</sup> As mentioned in Chapter 3, paragraph 3.28, the experiences of being sectioned described by the young people in this study all relate to the period prior to the introduction of the new Mental Health (Care and Treatment) (Scotland) Act 2003, the main provisions of which came into effect in October 2005.

7.23 The young people in this study found it particularly upsetting when NHS staff spoke to their parents without consulting them first, or against their explicit wishes, about what they considered to be private matters. Others recounted experiences of general practitioners whose priority appeared to them to be about getting them out of the office within 10 minutes, or who simply seemed insensitive or uninformed about self-harm. Others reported being accused by NHS staff of “attention-seeking”. One young woman clearly explained what impact being labelled as “attention-seeking” is likely to have on someone who self-harms:

*And the worst thing you can mention is ‘attention-seeking.’ That is, I’m sure loads of people don’t even mention that in a conversation, because the person will automatically take offence to it straight away. And it’s like, oh, it’ll just make the whole conversation close up. They won’t be entirely honest wi’ you. I’m just going wi’ my personal insight, but if somebody says that you’re something when you’re not, you’re automatically going to take offence to it. (Female, aged 22)*

7.24 Several young people from the south of Scotland told of trying to get admitted to their local psychiatric hospital at a time of crisis, and being refused. One young man expressed frustration that he had had to attempt suicide first before he could get any help for his severe depression.

7.25 In contrast to these largely negative experiences, a minority of the young people in this study appeared to have had relatively more positive recent experiences of psychiatric hospital. What seemed to make these experiences better is that the young person received some therapeutic input while in hospital — it wasn’t just about medication; their admission had been planned, to the extent that they had been consulted about it, or had even requested it; and their stay in hospital was short — only a few days until they felt more stable.

## **Medication**

7.26 As mentioned in Chapter 3, thirteen of the young people who participated in this study were on antidepressants at the time of the interview. Four others had previously been on antidepressant medication, and two of these said they had made a decision themselves to stop taking their medication. Several interviewees had also been prescribed anti-psychotic medication at different points in their lives to relieve symptoms of paranoia, hearing voices and hallucinations. Several others had been prescribed medication for chronic insomnia.

7.27 In general, the young people in this study said that they hated taking medication. However, about half of those still taking antidepressants acknowledged that they had been helpful. This was often discovered when they decided to stop taking their medication. However, others said that the medication they were taking made them feel “not themselves”. One young woman said she had stopped taking her anti-depressants because they made her feel *worse*. Others expressed frustration that they had been on prescribed medication for a long period of time before they had received any counselling or other therapeutic intervention to help them learn to cope with their problems.

## **Parents**

7.28 It was unusual for the young people in this study to have supportive families to fall back on in times of difficulty. However, a few did, and having a supportive parent to talk to was clearly very helpful for these individuals.

7.29 However, the way the support was provided was also important. One young woman explained why her father's style was more helpful than her mother's:

*My dad's always kind of just taken more of a sideline and listened, you know, sat there and tried a little bit harder to actually understand whereas my mum's the talker. She's the talker, she's the doer, and he's the one that sits back and listens. (Female, aged 22)*

7.30 Parents who made an effort to listen and understand seemed to be more helpful to these young people than parents who tried to 'fix' things. One young woman referred to this as "passive concern".

7.31 The process of receiving counselling seemed to have helped several of the young people in this study to begin to see their relationships with their parents in a different light. A few said that they had finally being able to talk to their parents about some of the difficulties they had had as adolescents, and found it helpful when their parents recognised and acknowledged how they had hurt their children.

## **Self-help**

7.32 Young people who appeared to be in the process of recovering from years of depression and self-harm talked about learning how to help themselves. This often involved finding ways of coping with their feelings in less self-destructive ways; setting small, achievable goals for themselves; and learning how to deal with the day-to-day pressures of life in a practical way. Some of the things young people did to help themselves included:

- Reading about self-harm and depression (to improve their knowledge of the subject and to get ideas about how to tackle it)
- Reading fiction ("I like reading about other people who have been through hard times and who have come out in a good way at the end. They give me hope and something to hold onto when it does get really bad.")
- Relaxation techniques ("...if I do them!")
- Punching a pillow
- Getting involved in voluntary work and helping others (the *see me* campaign and working with disabled people were two of a number of examples given)
- Getting involved in outdoor activities and challenges.

7.33 One young woman described a technique which she used to help herself feel better:

### ***The Rescue Box***

*The hospital helped me do a — it's called a rescue box for self-harmers, that you put like — you get like a tin or a box or something, and you put things that make you feel better inside it. It could be like, ideas or something to do. It could be like photos, just anything that makes you feel good or gives you ideas or something to do instead — like go for a walk or anything. And if you feel like self-harming, you can open the tin. And the first time I did it, it didn't work at all because the people that were doing it with me, they didn't, they weren't involved enough, so that they didn't have any suggestions. But last time when I was in hospital for a month they helped me and I managed to get quite a full box for, like, home. And they said to carry on at home and add to it. And my CPN will go over it with me if*

*I've got any questions about it and that. So that helps quite a lot. It's something that you do for yourself, so it does make you feel better. It's something you can do at four in the morning without having to phone anybody and things like that. You can open the box and have a look through it, and it's got, it's got loads of different stuff in it. Like there's a set of dominoes in there, and just bits and bobs to do, and things that remind you of what you've got to carry on for without self-harming — pictures of the baby and things like that. So it, it's quite helpful that. That's probably the thing that's helped the most so far. (Female, aged 23)*

## **Creative outlets**

7.34 The young people in this study also said they often found mental relief through writing, drawing, painting, composing or playing music. Interestingly, these creative outlets appeared to be gender-specific. Several of the young women (but none of the young men) reported that they kept diaries or journals and found these helpful in being able to get their thoughts “out of their head” so that they can then deal with them.

7.35 Four of the eight young men said that playing or composing music was something which they enjoyed and found very helpful. A few of the young women also said that they had written songs, or played musical instruments, but the young women in this group were more likely to find *listening* to music helpful.

7.36 Several said they found it therapeutic to write poetry, paint, draw or act.

## **Talking**

7.37 In discussing with this group of young people the things that had, and had not, been helpful to them, one theme which arose consistently was the helpfulness of having someone to talk to. The difficulty was in trying to find someone whom they trusted who would truly listen.

7.38 However, at the same time, it was very common for interviewees to say that they had found it extremely difficult to talk to anyone about what was going on in their lives. Indeed, it was not just difficult, but seemed to be impossible. One of the things young people said they found very unhelpful was being expected to talk “when they weren't ready” or “when they weren't able.”

7.39 In many cases, the ability to talk improved over time, as the young person (finally) found a doctor, nurse, counsellor or project worker whom they trusted, who made the time to listen. But there appeared to be a very fine line between “learning how to open up and talk about things”, and “not being badgered to talk if you don't feel like it.”

7.40 It was also not unusual for young people to say, in reflection, that they knew they needed help, and even that they *wanted* help, but they simply did not know how to go about getting it. It was for this reason, that many considered their self-harming itself to be “a cry for help”.

*I only had my mum and my step-dad, and I didn't have that many friends at school really. Just to feel that somebody was on my side. But I didn't know how to go about getting any of that when I was that age, because I was so intent on keeping*

*everything to myself. I never really sought any help like that until I was about eighteen or nineteen. (Female, aged 24)*

7.41 At the same time, two of the young men made the point that, once someone gets to the stage of planning a suicide, it is almost impossible to ask for help. In the view of these young men, intervention is needed at a much earlier stage, to help people *before* they get to the point where they are seriously thinking of taking their own lives.

### **What could make a difference?**

7.42 All of the young people who participated in this study were asked what they thought could be done to help reduce the risk of suicide among young people who self-harm, or what they wished someone had done for *them* that might have made a difference.

7.43 Not surprisingly, interviewees' responses to these questions were very similar to their responses about what was helpful and unhelpful. Things that young people said would have made a difference to them included:

- Having a more supportive family
- Not being bullied, or having help to deal with social and academic pressures at school
- Someone noticing and responding sensitively to the signs of their depression and / or self-harm at an earlier stage (i.e., at school)
- Greater awareness and understanding of self-harm among health professionals (both primary care and specialist).

7.44 Having someone to talk to, whom they trusted, and who really listened, at an earlier stage in their lives was also commonly mentioned by young people as something that would have made a difference to them. However, the point was also made (as mentioned above), that the experience of being *expected* to talk when they weren't comfortable with it, had made some individuals feel worse.

7.45 In considering the question of how to reduce the risk of suicide among young people who self-harm, the individuals who participated in this study had the following suggestions.

- Schools need to take even greater steps to prevent and deal with bullying than they are already taking.
- NHS services need to be more responsive to those who ask for help when they are feeling suicidal.
- Teachers, GPs and NHS emergency care staff need to be better trained to know how to respond appropriately and helpfully to young people who self-harm and who repeatedly attempt suicide. This might involve a young person talking to these professionals about their experiences.

- Self-harm support groups could be one way of providing young people with support from others who understand them, and could also help to reduce the sense of isolation that many of them feel.
- Greater support and intervention (possibly through parenting classes) should be provided to parents.

7.46 At the same time, it was acknowledged by some of the young people in this study that they themselves had to be ready to receive the help that was offered to them in order to really benefit from it. One young woman who was in the process of recovering after many years of self-harm put it this way:

*I suppose – thinking about the times that were most helpful and not helpful – the whole time that I was really, really ill, and that things got worse, was when I was hiding away from the world and I wouldn't tell anybody about anything. And I was just, sort of, listening to my own thoughts, and that's all I got. And even though it was really, really, really hard and people told me for ages, 'speak about it,' I wasn't listening to them. When I eventually did, it just seemed to change a lot of things. Just **saying** things – it wouldn't even matter if there was someone else there – just sometimes when I said things **out loud**, it rang a bell in my head, and I thought, **that's** why that's happening. But unless you speak about them, and I think, knowing not to feel **stupid** speaking about things – because I always thought that was a sign of weakness, getting upset and talking to somebody about things. Because it had always been **my** secret, and I was strong because of that. But if I'd carried on feeling like that, I wouldn't be here. So just knowing that there are people out there somewhere, and that it takes a while to get help. But you **can** get it eventually if you keep trying. And there are different types of help that you can get. It doesn't always have to be through organisations. Sometimes people in your family or your friends can be the most helpful. (Female, aged 24)*

## CHAPTER EIGHT      DISCUSSION AND IMPLICATIONS

8.1 This section draws together the main findings of this study, and identifies some of the implications for services, policy and public health, and future research.

8.2 The aim of this study was to investigate the links between self-harm and attempted suicide in young people — to find out how and why non-suicidal self-harming behaviour, which many would say is intended for coping and survival, can become suicidal; and to identify some possible ways of preventing suicide among young people who self-harm.

8.3 Much of the previous research in this field relates to large-scale epidemiological studies of people presenting to hospital. Community-based studies of young people's experiences of self-harm and attempted suicide are relatively recent, and in-depth qualitative studies among this population are uncommon.

8.4 It is important to try to get young people's own perspectives on self-harm and suicide, since these perspectives will give us a greater understanding of how to intervene effectively with this very vulnerable group. Many of the young people in this study reported feeling judged, misunderstood or simply ignored by services which could have helped them. Therefore, in addition to the research aims stated above, one of the unstated aims of this research was to give young people who self-harm an opportunity to have their voices heard, and thus to build on the work of the National Inquiry into Self-harm among Young People.

### **What kind of young people self-harm?**

8.5 The young people who took part in this research were a very diverse group with a wide range of backgrounds and experiences. Their lives were complex and sometimes chaotic. Multiple life difficulties and serious family problems were common. Difficult relationships with mothers, in particular, appeared to be a significant issue for both young men and young women. In addition, about half of the young people in this study said one or both of their parents had serious mental health problems and / or a drug or alcohol misuse problem. Three people reported having mothers who had attempted suicide on one or more occasions.

8.6 The characteristics of the young people in this study are consistent with the findings of other research which has investigated the factors associated with suicidal behaviour in adolescents. In particular, self-harm and attempted suicide in young people have been shown by other researchers to be associated with depression, anxiety, eating disorders, substance misuse, homosexuality or concerns about sexual orientation, physical and sexual abuse, dysfunctional family relationships, and self-harm and suicide attempts among family members or friends (Evans *et al* 2004; Beautrais 2003; Meltzer *et al* 2001; Hawton *et al* 2002).

8.7 About half of these young people had experienced homelessness and a quarter had received local authority care. All of them had had extensive support from NHS or voluntary sector mental health services, usually in relation to depression or anxiety, although two had also been diagnosed with a severe and enduring mental health problem (bi-polar disorder).

8.8 At the same time, over a quarter of this group had also attended some university. Moreover, at the time of interview, half were in (full or part-time) employment and others were enrolled in college courses. Four had responsibility for bringing up children.

## **Young people's experiences of self-harm**

8.9 On average, the young people in this study began self-harming at age 12. The methods of self-harm used by the young people in this study included a very wide range of behaviours. Cutting, burning, self-battery, bruising, hair-pulling and overdosing were common among this group. Eating disorders and drug and alcohol misuse were also considered to be forms of self-harm by *some, but not all*, of the young people in this study. Different methods were often used in combination, and the frequency of self-harming changed over time and in response to circumstances.

8.10 Most of the young people in this study had self-harmed for many years before anyone became aware of it. At yet, at some level, it seems people *were* aware that these individuals were often hurting themselves, or were frequently ill. While some young people took pains to hide the scars and marks of their self-harming, others appeared to have made less effort to do so. As a result, young people were often directly asked by friends or parents how they had hurt themselves. However, they seldom told the truth, and it seems that those who asked were generally satisfied with the false explanations given. Injuries, broken bones, cuts, bruises and even frequent vomiting were easily attributed to anything other than the young person him / herself. Even when parents actually witnessed their child self-harming, they often did not recognise it for what it was.

8.11 Few of the participants in this study knew of anyone else who self-harmed before they themselves began to self-harm. So-called copy-cat behaviour was rare in this group. Rather, self-harming began as an impulsive response to deep distress, anger, frustration or self-hatred. In general, young people did not initially understand themselves what it was they were doing or why they were doing it, and it appears that for some, the recognition of their own behaviour (or aspects of their behaviour) as 'self-harm' evolved over time.

8.12 Young people's reasons for self-harming and their frequency of self-harming appeared to change in response to circumstances. Some considered their self-harming as a kind of addiction. It 'works' because it makes them feel better. However, the point was also made that a positive change in circumstances can sometimes lead to a cessation of self-harm, even temporarily.

## **Young people's experiences of attempted suicide**

8.13 The average age of first suicide attempt among these young people was 16 /17. It was common for the young people in this group to have made more than one suicide attempt, and nearly half of the interviewees said they had attempted suicide on more than three occasions. All of the participants in this study reported suicidal feelings and impulses over a number of years which had not been acted on.

8.14 Four individuals attempted suicide *before* they began self-harming and two others attempted suicide at the same age at which they began to self-harm. Several of the interviewees had attempted suicide without anyone else ever learning of it. In most cases, these individuals took an overdose believing it would be fatal, and then woke up the next morning feeling ill – and never spoke to anyone about what they had done.

8.15 In some cases, a specific event prompted the young person to try to take their own life. However, it was more common for the suicide attempt to follow on from a long period of

feeling depressed, isolated, stressed and exhausted. Very few ever told anyone that they were thinking of taking their own lives prior to attempting suicide.

8.16 Overdose was the most common method of attempted suicide used by the young people in this study – both among young women and young men. Young women were more likely than young men to have made multiple suicide attempts through overdosing. This finding appears to be consistent with other research (discussed in Chapter 6) which shows that women are more likely than men to attempt suicide.

8.17 It was common for young people to change their minds following an attempted suicide by overdose, and then to phone an ambulance or friend to take them to hospital. On the surface of it, this behaviour appears to be identical to the use of overdosing as a form of self-harm (i.e., “to get a few days rest”) for which the young person might also end up in hospital. The only difference between the two is the young person’s intentions.

### **What are the links between self-harm and suicide?**

8.18 The main questions which this research set out to answer were: What are the links between self-harm and suicide? And what are the processes by which self-harm becomes suicidal?

8.19 In considering the latter question first, is it clear that this question contains an assumption which must now be laid bare. The assumption was that self-harm would come *before* attempted suicide. However, as stated above, four of the young people in this study attempted suicide *before* they began to self-harm and two attempted suicide at the same age at which they began to self-harm. Nevertheless, in general it did appear that young people’s first suicide attempt came, on average, about 4-5 years after they started self-harming.

8.20 In considering the first question – what are the links between self-harm and suicide? – the findings of this study indicate that, *in general*, young people who self-harm see self-harm and attempted suicide as two completely different things. Sometimes the behaviour may be the same, and the outcome may even be the same, but the motivation and the intention are entirely different. In some cases, the processes leading up to the behaviour may also be different. For some young people, suicide was very carefully planned (unlike their self-harming), for others it was an impulsive act, but one which was the culmination of a long period of depression, isolation and exhaustion. Young people were clear that when they were self-harming, their intention was to stay alive. However, in attempting suicide, their intention was very definitely to die. The fact that, having made an attempt to kill themselves, young people sometimes changed their minds, does not in any way lessen the life-and-death seriousness of what they did.

8.21 So, self-harm and suicide are *different*, but are they linked in any way? The findings of this study would suggest that they are.

8.22 The young people in this study said they self-harmed for a variety of reasons: to cope, to express anger, to punish themselves, to take a break, to make themselves feel alive, to relieve tension, to distract themselves from emotional pain, and to have a sense of control. Self-harm is a symptom of something wrong. The ‘something wrong’ may relate to the young person’s external circumstances but, more importantly, it is an outward manifestation of the young person’s internal response to their circumstances. This internal response may include self-hatred, rage, depression, severe anxiety and despair. All of the young people in this study

had had suicidal feelings over a long period of time. Many said that it was their self-harming that kept them alive, or that they self-harmed because they *wanted* to live.

8.23 However, when the pressures of life became too difficult to deal with, and self-harm no longer seemed to work, then the suicidal feelings took precedence and suicide became a serious option. A particular incident, such as the break-up of an engagement, the death of a significant other, a violent argument with a parent or friend, could be the proverbial straw that broke the camel's back. Or it might be that the young person was just too exhausted and depressed to carry on coping by themselves any longer.

8.24 If a young person has self-harmed for a number of years, and eventually comes to a point where they do attempt suicide, they have already acquired a great deal of information about what their body can take – and so they know that any suicide attempt needs to go that much further. This can be illustrated in the example of suicidal cutting: those who had attempted suicide through cutting said that they tried to cut themselves more deeply than they ordinarily would when they self-harmed. Inevitably, suicidal cutting resulted in more serious physical damage.

8.25 It is also crucial to bear in mind that young people who self-harm *can* end up dying accidentally. Despite the view expressed among some young people in this study, that people who self-harm “know just how far they can go” before their self-harming is likely to be fatal, others admitted that it *is* possible to get it wrong, particularly where self-harming and attempted suicide involves overdosing. Even more concerning was the sentiment expressed by one young man in this study that some individuals who self-harm may not actually care whether they live or die.

8.26 Changes in young people's self-harming behaviour can also be a signal of their increasing risk of suicide. The young people in this study said that their self-harm changed in significant ways just before a suicide attempt. In some cases, the self-harming became much worse, in particular, more frequent. In other cases, the young person stopped self-harming altogether because it “wasn't working anymore”.

### **Young people's attempts to seek help**

8.27 It was not unusual for the young people to say that there were times in their lives when their self-harming was “a cry for help.” They also explained how difficult it was to ask for help in any other way. Depression, frustrated anger, low self-esteem, social isolation, lack of support and a real (not merely imagined) powerlessness were common among this group. Given this situation, it is not surprising that they would feel unable to articulate their distress. At the time, they felt there was no one they could speak to, who would listen, understand, and not make matters worse.

8.28 Not all of the young people in this group described their self-harming as “a cry for help”. Nevertheless, it was clear that the “cry for help” explanation for their self-harming was more acceptable to them than being labelled as “attention-seeking”. The latter was considered to be extremely unhelpful and even offensive, and yet, it was not unusual for those who participated in this study to say that they had been referred to as “attention-seeking” by NHS professionals at different points in their lives.

8.29 It would seem that, in the minds of these young people, “attention-seeker” means “time-waster,” and this perhaps explains why so many of these individuals perceived that NHS staff were too busy to care.

### **Gender differences**

8.30 The study experienced difficulty in recruiting young men to take part through voluntary sector self-harm support services. As discussed briefly in Chapter 6, this may be a reflection of apparent gender differences in the prevalence of self-harm. However, there are some alternative explanations that may also be worth considering.<sup>12</sup>

8.31 As mentioned in the Introduction to this report, our best information about the prevalence of self-harm among young people in the UK comes from a large community-based survey of 15- and 16-year-old school pupils undertaken by Hawton and colleagues in England in 2000 – 2001.<sup>13</sup> However, what the findings of this survey indicate, is that young women are more likely than young men to *self-report* that they have self-harmed. This finding does not necessarily indicate that young women are, in fact, more likely than young men to self-harm. It could be that young men are as likely as young women to self-harm, but less likely to describe, or recognise, certain aspects of their behaviour as self-harm — like the two young men in this study who did not recognise that punching walls, cutting yourself when you were high on drink and drugs, and regularly getting into fights, might be considered as forms self-harm.

8.32 Hawton and colleagues also acknowledged that there may be a number of other explanations for the apparent gender differences in the prevalence of self-harm (Hawton *et al* 2006, p. 66). One of these explanations is that “boys more readily use outwardly directed means of dealing with distress and anger, such as delinquent behaviour, fighting and other types of aggression, and are perhaps also more likely to use alcohol or drugs to smother bad feelings.” In other words, young men’s attempts to deal with their mental distress get wrapped up with, and labelled as, anti-social behaviour rather than self-harm.

8.33 The findings of this study would seem to support this as one possible explanation for the differences in prevalence of self-harm between young men and young women. And while it would be difficult to argue that anti-social behaviour should be relabelled as self-harm, there is certainly a great deal of evidence to indicate that young men are more likely than young women to misuse drugs and engage in delinquent behaviour. Moreover, it is well-known that there are very high rates of mental illness among young men (and indeed young women) in drug treatment services and prisons. It has also been recognised for some time, that the mental health needs of these individuals are often unmet by the services with which they come in contact (Scottish Executive 2003). This situation is clearly reflected in our annually reported figures on drug-related deaths. For example, in Scotland in 2005, one-third (30%) of the 336 official drugs-related deaths were attributed to intentional self-poisoning or undetermined intent (GROS 2006).

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<sup>12</sup> Further difficulties were encountered in attempting to recruit young men through other voluntary sector agencies. These difficulties are discussed in some detail in the annex of this report.

<sup>13</sup> See Hawton *et al* (2006) for a full and detailed report of the findings of this study.

## **Strengths and limitations of the study**

### ***Reliability of data***

8.34 This study involved one-to-one depth interviews with 20 young people. Interviews ranged in length from 45 minutes to an hour-and-a-half. No information was available about the young people apart from what they themselves provided during the interview. The findings presented here and the interpretation of those findings are limited to the extent that they are based on what the young people chose to reveal about their lives. Many were recalling events that took place a number of years ago — in some cases 10 years ago — and obviously there is a question about how well they were able to accurately recall or describe their own motivations and responses to events in the past. Nevertheless, the findings from this study are highly consistent with other published research into the characteristics and motivations of young people who self-harm (Hawton *et al* 2006; Sinclair & Green 2005; Mental Health Foundation 2006).

8.35 The fact that young people were recalling events which may have taken place a number of years ago can be considered a *strength* of the study rather than a weakness. The ability of the young person to reflect on their experience during the interview allowed for a greater exploration of those experiences than might have been possible if they were still in the midst of them. This was confirmed by the young people themselves, as they consistently said that it took a very long time for them to learn how to talk about their feelings and their experiences.

### ***Possible sample biases***

8.36 Every effort was made to include young people from across Scotland in this study. However, in the end, nearly half of the sample came from Edinburgh. This was because of the ease of recruiting young people (in particular, young women) through the large Penumbra self-harm support service in Edinburgh. However, the ‘Edinburgh bias’ in the study sample is probably less significant than the urban bias.

8.37 A majority of the study participants came from large urban areas — Edinburgh, Glasgow, Dundee and Aberdeen — and most of the remaining interviewees came from large towns. Very few came from rural areas. This is almost certainly a reflection of the lack of availability of services in the rural areas of Scotland, rather than a reflection of the prevalence of self-harm and attempted suicide in these areas. In fact, published suicide statistics indicate that there are high rates of suicide in the remote and rural areas of northern and western Scotland, particularly among young men (Brock *et al* 2006; Platt *et al* 2007). It is not clear to what extent the findings of this study reflect the experiences of self-harm and attempted suicide of young people living in remote and rural areas. However, it seems likely that individuals living in these areas would be contending with even greater isolation, and have even fewer means of getting help than those in urban areas. The rural dimension also increases the risk of death simply because young people living in remote areas do not have the same level of access to emergency services if, for example, they change their minds following a overdose.

8.38 The young people in this study were recruited through voluntary sector agencies which they were involved in. It is possible that the views and experiences of young people who are *not* involved in services would be different from those expressed here. On the other hand, it is worth noting that most young people in this study had been self-harming for some time

before anyone became aware of their self-harm. By that time, several had already made their first suicide attempt as well. Therefore, although the young people in this study were all recruited through services, in reflecting back on their experience of self-harm and attempted suicide, they were also able to share an important perspective of young people *not* in contact with services.

8.39 Thirteen of the individuals who took part in this study were recruited through a single agency, Penumbra, which provides self-harm support services to young people. One other interviewee was recruited through another agency specifically targeted at young people who self-harm. All these young people had particularly high levels of awareness and understanding of the whole issue of self-harm. However, there did not appear to be major differences between these fourteen individuals and four of the other six interviewees who had been recruited through other types of agencies. Only two individuals in this study, both young men, had relatively low levels of awareness of the issue of self-harm — and, so it seemed, of their own self-harming behaviour.

8.40 Finally, the ability of the study to compare the experiences of young men and women has been limited to some extent by the difficulty in recruiting young men to take part. The achieved sample of eight men is probably too small to be able to identify the full range of issues that might be relevant to young men in relation to the question of how self-harm is linked to suicide. Nevertheless, some important issues *have* been highlighted, and this study has also raised some questions which could be addressed through further research.

### **Implications for services**

8.41 The findings of this study have some important implications for a wide range of services. As mentioned above, the young people who took part in this study were recounting experiences and events which took place over a number of years. It is possible — indeed, probable — that service structures and service provision have changed in many areas during that time. For example, anti-bullying campaigns have been rolled out in schools across Scotland, and the introduction of the new Mental Health (Care and Treatment) (Scotland) Act 2003 means that people's experiences of compulsory treatment are almost certainly different today than they would have been for these individuals. Nevertheless, this research indicates that more needs to be done.

8.42 Young people who self-harm, and who are at risk of suicide, may be in contact with a wide range of services which are completely unrelated to their self-harming behaviour. These may include schools, colleges and universities, housing and homelessness services, training and employability services, addiction services, social work services and prisons. The young people in this study consistently met with a lack of understanding in relation to self-harm among many of the services they came in contact with. Awareness of the issue of self-harm should be raised among staff in these services. Organisations and agencies may also need to review their policies and practises in relation to self-harm, and to develop policies and practices which are supportive of young people in distress, rather than punitive.

8.43 On average, young people attempted suicide 4-5 years after they began self-harming. If the young person's self-harming can be identified quickly, this 4-5 year period clearly provides a crucial window of opportunity to intervene to prevent suicide. The problem is that the self-harming often stays hidden — and even when it does not stay hidden, there is often a failure by parents to recognise and act upon it. Teachers, youth workers and GPs clearly have an important role here.

8.44 A small proportion of the young people in this study attempted suicide before they began to self-harm. These individuals also require help, both to prevent further suicide attempts, and to prevent self-harming.

8.45 Services (including schools and youth work services) need to recognise that young people's self-harming behaviour may take a variety of forms — some of which might be classed as anti-social behaviour. While some young people may make a great effort to hide the results of their self-harming, others may not. Teachers, youth workers, social workers, doctors and nurses who suspect self-harm should not hesitate to ask the young person directly but gently if they are alright, and if they would like to talk. Although the young person may not (be able to) respond initially, continuing to offer invitations and opportunities to talk will communicate care and concern and may eventually be taken up.

8.46 Schools could play an important role in identifying self-harming behaviour at an early stage, and providing young people with confidential support. However, when the young people in this study disclosed their problems to their teachers, it seemed that the response they received most often was panic. Classroom and guidance teachers and school nurses may need training and support to feel confident in responding to young people who are self-harming, since the issues they disclose may concern physical or sexual abuse, neglect, parental mental health and substance misuse problems, sexual identity problems, as well as serious depression and anxiety.

8.47 Schools have worked very hard in recent years to eradicate bullying. It is possible that the experiences related by young people in this study, some from 5-10 years ago, are no longer the experiences of young people today. However, this is probably not the case — at least not in all schools. The effect of bullying and social isolation at school on a young person whose family life is also in chaos can be devastating, and schools must continue to make every effort to address this problem and support young people who are affected by it.

8.48 For young people who self-harm, and who are contemplating suicide, asking for help is extremely difficult. The findings of this study indicate that increasingly serious episodes of self-harm, and repeated overdoses may be an attempt to seek help. NHS services need to be aware of this, and not dismiss the young person as “attention-seeking”. Negative and judgemental responses by professionals only reinforce the individual's beliefs that no one cares about them.

8.49 GPs and other health professionals need to be aware of the potential for young people to overdose on tablets prescribed for insomnia, anxiety or depression, which may be taken in combination with paracetamol, over-the-counter pain-killers and alcohol. Psychological interventions aimed at improving coping skills and self-esteem should be offered to all young people who present to primary care with a mental health problem. Unless their problems are very severe, young people will generally find it easier to engage with young-person-friendly services in the voluntary sector or a community psychiatric nurse in the first instance, rather than a psychiatrist.

8.50 Young people felt that having someone to talk to, whom they could trust, and who truly listened was one of the things that helped them most. However, they stressed that being pressured to talk was unhelpful. “Passive care”, as one young woman called it, is needed. Young people have to be given help in ways that feel comfortable to them. Drop-in services, self-harm support groups, and one-to-one sessions with a trusted project worker or

community psychiatric nurse were seen as particularly helpful ways of meeting young people's needs.

### **Implications for policy and public health**

8.51 Further work needs to be done to raise awareness among parents of adolescent children, teachers and among young people themselves. In particular, young people who self-harm need to be encouraged to seek help for the way they are feeling, and they need to be given specific advice on how they can do so. In general, this help will best be provided in schools, but it could also be made available through primary care services and voluntary sector mental health services.

8.52 As part of its focus on improving intervention with people at risk of self-harm or suicide, Scotland's Mental Health Delivery Plan has made a commitment to train 50% of key frontline healthcare professionals in using suicide assessment tools / suicide prevention programmes by 2010. However, in terms of self-harm, the focus of this commitment is on "people whose self-harming behaviour puts them at high risk of suicide." The findings of this research suggest that *all* people who self-harm may be, or may become, at risk of suicide. Therefore, professionals need to know how to intervene appropriately in *all* cases of self-harm, irrespective of the person's assessed risk.

8.53 In relation to this, the evaluation of the first phase of Choose Life recommended that NICE guidelines on the treatment of self-harm should be adopted in Scotland (NICE 2004). This recommendation has been agreed by the Scottish Executive.<sup>14</sup>

8.54 The young people in this study reported being adversely affected by the mental health problems of their parents. The relationship between parental mental health problems and self-harming / suicidal behaviour in young people has been established by previous research (Meltzer *et al* 2001) and a family history of self-harm / suicide attempts is one of the main risk factors associated with self-harm and attempted suicide in young people (Evans *et al* 2004; Beautrais 2003; Hawton *et al* 2002). It may be useful to consider how parents and children in these situations can be better supported.

8.55 The findings of this study would support the recommendation made in relation to the evaluation of the first phase of the Choose Life strategy and action plan — namely that Choose Life should more formally incorporate action and interventions targeted towards non-suicidal self-harm. Self-harm is a sign of serious mental distress. If left undetected and unaddressed, this distress has the potential to become suicidal. The young people in this study clearly felt that when self-harm failed to work, suicide was an option.

### **Implications for further research**

8.56 There is a need for further qualitative research on the links between self-harm and suicide in young men. If these young men are in contact with services at all, they are likely to be found in drug / alcohol treatment services, housing and homelessness services and criminal justice services, rather than in services targeted at young people who self-harm.

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<sup>14</sup> The Scottish Executive's response to the recommendations of the Choose Life evaluation is available from the Choose Life website at: [www.chooselife.net/Evidence/ResearchandEvaluation.asp](http://www.chooselife.net/Evidence/ResearchandEvaluation.asp).

8.57 Finally, health professionals and researchers in this area could usefully begin to make the same distinction that young people make themselves between non-suicidal self-harm and attempted suicide. Grouping both these behaviours together under a single label, ‘deliberate self-harm,’ is restricting our ability to truly understand and tackle these issues.

## Conclusion

8.58 Many of the young people who participated in this study were in the process of recovering. Some said they had not harmed themselves for some time, while others said they were still self-harming but very infrequently. Many said their confidence had grown as they learned how to cope in new ways with the stresses and pressures of their life. Some spoke of wanting to help other young people who are in the same position they had once been in.

8.59 This report closes with messages from three young people about what gives them hope:

*I want tae live for me. I want tae help people that's been in the same situation as me. That's my ultimate goal in life — is just tae help other people in any way possible. If I help one person, that's fantastic. If I help a hundred, that's even better, but as long as I help somebody, ken. I dinnae want tae die. I might feel like it sometimes, but I know in my heart that I dinnae want tae die, and that's been like that for a while. I think that just being able to open up in the last while has been great. (Female, aged 23)*

*Hope? I think it's people that are in my life who give me hope — along with the direction my life is going in, because I'm more comfortable with my family now because they know who I am. I'm more comfortable with my friends... I think it's more clear that there isn't really another road to go [on]. We're all living as we are. There's so much crap and shit going on around the place that we have to be more positive in our outlook because we only get what we put in, and I've not put a lot in yet, so I've got to try and rectify that... I'm sort of making my own future. (Male, aged, 24)*

*I suppose, seeing the way that my life has progressed, how much it has since — cause I do sometimes look at my life, and it's like, fair enough, I haven't got a job because I still do have a lot of problems, and I'm still finding things hard. But if I look back on how, like, not being able to go out to do my shopping and not being able to walk down the street. I'd have something really important to do and appointments, and I'd miss the whole day because I couldn't leave the house. And I think — looking back on that, and knowing that I could do that without half the trouble that it caused before — that really helps me and makes me feel that I have actually done something for myself, and that I'm getting stronger. And it makes me feel like, well, if I've made that much progress in that amount of years, then hopefully the rest of the time will be even better. (Female, aged 24)*

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## **ANNEX 1: A REFLECTION ON THE PROCESS OF UNDERTAKING AN IN-DEPTH QUALITATIVE EXPLORATION OF THE LINKS BETWEEN SELF-HARM AND SUICIDE IN YOUNG PEOPLE**

This section provides a personal reflection on the process of carrying out research among a very vulnerable group of young people. The aim of sharing this reflection as part of a report of the findings is so that other researchers working with this, or similar groups of young people, may learn something from the experience of the researcher who carried out this study. It is very much hoped that anyone reading this section will read it with this in mind.

The focus will be on:

- the ethical procedures used in the study
- the difficulties that arose in recruiting young men to participate, the attempts that were made to address those difficulties, and possible reasons why so many of those attempts failed
- the interviews themselves

### **Ethical procedures**

The ethical procedures used in this study were developed in consultation with practitioners who worked with young people who self-harm. In reflection, the decision to include and involve practitioners in this process was absolutely necessary — for several reasons.

First and foremost, it ensured that the conduct of the study was truly ethically sound. While an experienced researcher should already have an awareness of the ethical issues involved in doing research with vulnerable people, practitioners who work with these groups day in and day out have a level of awareness and experience that even very good researchers may not have.

Second, the process of working together with practitioners on the ethical procedures gave them the opportunity to meet the researcher, ask questions and get to know her. This process was invaluable for getting practitioners' support and assistance with the study.

The researcher was especially grateful for the input of the Penumbra practitioners in the development of the participant information leaflets. The first draft of the leaflet — which, incidentally, the researcher felt was really quite good — was considered by Penumbra staff to be “not very young-person friendly.” The final draft of the leaflet was a great improvement.

In a study such as this, there was no question that young people would need to be given an opportunity to ‘debrief’ following the interview. This debriefing was provided by the young people’s own project workers. This researcher can only re-iterate how very important and necessary these arrangements were. An effort was made to finish all interviews on a positive note — i.e., through discussion of what things have been helpful over the years, and what, if anything gave the young person hope for the future. However, the bulk of the interview was an hour of discussion of some very difficult subjects. Even for those young people who were clearly well on the way to recovery from depression, it can not have been easy to revisit painful memories. One project worker put it very well: “These interviews leave the young

person in a bad head space.” Time was needed afterwards to bring them back into a better head space. This researcher is grateful to all the project workers who played a vital role in this study by giving their young people the time and support they needed after the interviews.

It should perhaps be mentioned that this study was *not* submitted for review to an NHS ethics committee. This was not seen to be necessary because the original plan for the study was to recruit all interviewees through a single voluntary sector agency.

### **Difficulties in recruiting young men to participate**

As has been mentioned at various points throughout this report, this study ran into difficulty very early on in relation to recruiting young men to participate. This was because the young men simply weren't there. Having said that, there was one young man who had initially agreed to take part in the study, who ended up withdrawing prior to the interview. Apart from this one individual, all of the young people whose names were passed to the researcher agreed to take part. It is not known whether any individual who was invited by a project worker to participate in the study, declined to do so before their name was passed to the researcher.

Since one of the main objectives of this study was to compare experiences of self-harm and attempted suicide between young men and young women, every effort was made to recruit a sufficient sample of young men into the study. However, because the researcher had not sought NHS ethics approval, it was not possible to recruit young men through NHS services. Instead, a very large number of voluntary sector agencies from all over Scotland were contacted about the study and asked to participate. These included services for drug and alcohol users, services for young offenders, services for young people with mental health problems, services for young homeless people, services for young people in care, etc, etc.

This process was extremely time-consuming and not a little frustrating. Project managers frequently expressed a keen interest and enthusiasm for taking part, and indicated that their project had one or more young people who would meet the eligibility criteria. However, when project workers were approached about the study, it seemed that very few had any clients who would be eligible to take part after all!

It is not known *why* so many agencies declined to participate in this study, when some of them almost certainly would have had young people who met the eligibility criteria. It is possible that the project workers in these agencies considered their young people too vulnerable to take part in study on self-harm and suicide. Or it is possible that the project workers did not have the time, or feel equipped to provide their young people with the debriefing time they would need after the interview. It is also possible that many of the project workers were aware of their young people's self-harm and suicidal feelings, but had not ever directly discussed these things with the young person. Therefore, it would be very difficult for them to approach a young person to ask them to take part in a study on this subject. All of these possibilities are speculative, but any one of them would be a valid reason for declining to take part.

The main disappointment was that the young people in these agencies never got the chance to hear about the study and decide for themselves whether they wanted to take part.

In any case, this researcher is very grateful to those seven agencies (in addition to Penumbra) which agreed to take part in this study, and to those project workers who gave their young people the choice to participate.

## The interviews

All of the young people in this study were told that they could meet the researcher first before deciding whether to take part in the study. However, only a small number took up this offer. In addition, all of the young people were told that they could have a friend or project worker sit in on the interview with them. Three individuals decided to do this.

Only one of the young people who participated in this study became distressed, and began to cry during the interview. When this happened, the interview was stopped immediately, and the young person was provided with tissues, a cup of tea, and reassuring and sympathetic words. After a few minutes of chatting about other things, she seemed to recover, and assured the researcher that she *did* want to continue with the interview. She did not become distressed again during the remainder of the interview.

While this was the only person who became distressed *during* the interview, project staff also fed back to the researcher that at least one other individual was quite upset *after* the interview, although she appeared to the researcher throughout the interview to be completely calm and, in fact, quite chatty. The only change in her mood appeared to take place once the interview had ended and the tape recorder turned off — at which point she still appeared calm and relaxed, but became very quiet.

Prior to two other interviews, project staff had warned the researcher that the interviewees were feeling tearful and *might* cry during the interviews, although they also stressed that both these interviewees very much wanted to do the interview, and that they did *not* want to reschedule it. In the event, neither of these individuals *did* become distressed. However, their responses to questions were short almost to the point of brusqueness. Neither volunteered any additional information; they merely answered the questions as briefly as possible. The researcher felt in both these interviews that she had failed to put the interviewee at ease and make a real connection with them. The researcher's thought, immediately after these interviews, was that perhaps the interviewee had not really wanted to take part after all, but had not felt confident enough to withdraw once they had agreed. However, in reflecting back on both these interviews, and in speaking to project staff afterwards, it would seem that these two individuals *did* very much *want* to participate in the study, but possibly did not want to *cry* in front of the researcher and so were reluctant to say any more than was absolutely necessary in response to questions, for fear they might become distressed.

Despite the obvious difficulty of the subject matter for many of these young people, this researcher had the impression that all those who took part, very definitely *wanted* to tell their stories, and appreciated the chance to participate in a research study where they could do so. This researcher is grateful to all the young people for their time and their willingness to talk about such difficult issues with a complete stranger.