



Youth and self harm: Perspectives - A report

SAMARITANS

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This report represents the work of an association between the Centre for Suicide Research, University of Oxford and Samaritans.

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We know that self-harm is not about dying, it is about living. It is a way of coping with emotional distress, a way of releasing the frustrations and anger that build up inside. It's a way, 19 year old Neil tells me, "of screaming without opening my mouth".

Nearly half the population know someone who has self-harmed. The number of teenagers who self harm is rising at an alarming rate. 25,000 teenagers are referred to their local hospital each year as a result of self-harm. Anyone who self harms is 100 times more likely to go on to take their own life. Behind these stark statistics lie human stories, shattered hopes and dreams of young people who desperately need emotional support in order to find the way through.

We are committed to responding to the changing needs of people experiencing depression and suicidal feelings. We offer everyone, everywhere the time and space to find the way through. As part of this we must always be moving forward as we develop our emotional support service to help people most in need.

This research, undertaken by the Centre for Suicide Research at Oxford University, will inform our thinking about how best to support young people at risk of self-harm. For the first time, there is now a comprehensive understanding of why young people self-harm. We hope that not only will this inform our work, but help other experts working alongside young people understand more about what is happening in our society. Ultimately, by working together, we hope to develop practical answers and new ways of supporting vulnerable people at risk of self-harm and dying by suicide.

Simon Armson
Chief Executive
With Samaritans

Introduction and Overview

Deliberate self-harm and suicide in adolescents

Deliberate self-harm is a term used to describe non-fatal self-poisoning (overdoses) and self-injury (e.g. self-cutting). In the United Kingdom, large numbers of adolescents present to general hospitals each year because of deliberate self-harm. On the basis of data from the Oxford Monitoring System for Attempted Suicide it was estimated that in the late 1980's there were at least 19,000 presentations to hospitals of under 20 year-olds per year in England and Wales (Hawton and Fagg 1992). Since then, rates in teenagers have risen, mainly in males (Hawton et al 1997), so the number of cases is now probably of the order of 25,000. Findings from the WHO:EURO study of Parasuicide, a long-standing study of deliberate self-harm in several centres throughout Europe (Schmidtke et al 1996), indicate that the rates of deliberate self-harm in older adolescents in the UK are, with those in French adolescents, the highest in Europe and three or four times higher than in some countries such as The Netherlands (Grootenhuis et al 1994). This pattern has occurred against a background of rising rates of completed suicide in 15-24 year-olds in the UK due to a very large increase in suicides by young males (Charlton et al 1992; Hawton 1992), a pattern that has only shown signs of reversal in the past couple of years (Kelly and Bunting 1998).

There has been considerable debate about the best terms to use for non-fatal acts of deliberate self-poisoning or self-injury. In part this is about the need to avoid using the term 'attempted suicide' for acts where death was clearly not intended. It is also about what term to use to include all acts of deliberate self-poisoning or deliberate self-injury, irrespective of the motivation or intention. It is now customary in clinical practice and research in the United Kingdom to use the term 'deliberate self-harm' for this purpose. Some people prefer the term 'self-harm'. Both these terms are used in this report. They should be taken to refer to both self-poisoning and self-injury.

Deliberate self-harm can be dangerous behaviour even when death is not intended (Hawton et al 1982). Young people who take overdoses are often unaware of the dangers of what they are doing - for example, self-poisoning with paracetamol. Deliberate self-harm clearly represents considerable distress and may be related to psychiatric disorder, particularly depression (Kerfoot et al 1996; Burgess et al 1998). It is often repeated; some 10 to 15 per cent of adolescents who present to hospital following self-harm repeat within a year and re-present to the same hospital (Hawton and Fagg 1992; Hawton et al 1999). This figure is a considerable underestimate of the total number of repeat episodes as some will go to different hospitals and many more will probably not be seen by clinical services.

Community prevalence of deliberate self-harm and suicidal thoughts in adolescents

Studies in several other countries, especially in Europe and North America, have shown that when community samples of adolescents are screened a sizeable proportion report that they have carried out deliberate self-harm acts. The majority of these have not come to medical attention. The prevalence of actual acts of deliberate self-harm has varied. Examples of findings from European studies are as follows: 2.2 per cent in Dutch secondary education students (Kienhorst et al 1990), 3.0 per cent ('suicide attempts') in older Swiss adolescents (Rey et al 1997), 3.6 per cent ('trying to hurt self', 'trying to kill self') in Swedish school students (Ivarsson and Gillberg 1997) and 8.3 per cent ('tried to take own life') in Norwegian adolescents (Rossow and Wichstrom 1994). Rates are likely to be higher when questions are asked about self-harm as well as about attempts to end life. Rates are higher in girls than boys in most studies. Very much larger proportions of girls have contemplated suicide or deliberate self-harm, with figures of between 8.2 per cent and 24.1 per cent in the above studies.

Until recently, no sizeable community studies of deliberate self-harm and suicidal thoughts in adolescents have been carried out in the UK. With the exception of Meltzer et al (2000), who conducted an interview-based study of 4,323 adolescents and their parents, studies that have been conducted in this field have been small. For example, in a study of 529 girls aged 15 to 20 years who were screened for evidence of depression, Monck and colleagues (1994) reported that nearly 13 per cent had experienced suicidal ideas in the month beforehand. In a student sample in Birmingham, Salmons and Harrington (1984) identified a history of suicidal thoughts 'at any time in the past' in 63 per cent of females and 45 per cent of males, with actual acts of self-harm in 4 per cent and 1.5 per cent respectively. In a recent survey of Oxford University students, thoughts of suicide at 'any time' were reported by 35 per cent of the females and 31 per cent of the males, with 'very recent thoughts' in 8 per cent of males and 7 per cent of females. Actual suicide attempts were reported by 4 per cent of females and 3 per cent of males, and self-harm by cutting or other means by 10 per cent of females and 5 per cent of males (Sell and Robson 1998). A recent unpublished report of a survey in North London conducted by Samaritans in workshops run for young people aged 13 to 25 years of age indicated that 11.4 per cent had tried to kill themselves at some time, and over 40 per cent had felt that there was no point in living. Overall, these studies suggest that deliberate self-harm and suicidal thoughts are likely to be common among adolescents in the UK and highlight the need to obtain accurate figures for these phenomena.

This report presents the findings from:

- A systematic review of the international literature on deliberate self-harm and suicidal thoughts in adolescents.
- A school based study of deliberate self-harm and suicidal thoughts in 15 and 16 year-olds. This is the first large survey of the prevalence of deliberate self-harm and suicidal thoughts together with associated risk factors in adolescents in the United Kingdom. The study was based on a sample of more than 6,000 adolescents aged 15 and 16 years in 41 schools in England.

Introduction and Overview

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The results of the survey indicate that the problem of deliberate self-harm and suicidal thoughts in adolescents in the community is substantial. They also provide a clear indication of risk factors in terms of the background of adolescents, their problems and their psychological characteristics

Chapter 1 of this report summarises the results of a systematic review of the international literature on self-harm and suicidal thoughts in community or school samples of adolescents. Chapter 2 provides the reader with an overview of the Schools Study and the methodology used. The study findings are described in Chapter 3. Chapter 4 offers some conclusions and considers the implications of the survey findings. Chapter 5 considers the question of what should be done to help adolescents in the light of the survey findings.

International Literature Review: Summary

Suicidal phenomena in adolescents: A systematic review of population-based studies

Despite a relatively large number of community-based studies the evidence concerning the prevalence of deliberate self-harm in adolescents in general population samples is contradictory. The vast majority of community-based studies have been carried out in the USA and Europe (excluding the UK) but there is little consistency even from studies within the same continent. In the USA, for example, the lifetime prevalence of attempted suicide has been reported to be as low as 3 per cent (Lewis et al, 1988) and as high as 30 per cent (Dinges and Duong-Tran, 1994).

De Wilde and Kienhorst (1994) carried out a review of population-based studies conducted in the Netherlands with the aim of identifying demographic and methodological factors that account for the variance in prevalence of 'suicide attempts'. Characteristics that they found to be associated with prevalence were: anonymity, as substantially higher rates were found in anonymous studies compared with non-anonymous studies; terminology, as higher rates were found in studies that used the phrase 'ending your life' than in studies that used the phrase 'attempted suicide'; and age, because studies with younger adolescents had higher rates than studies with older adolescents.

Safer (1997) reviewed many of the worldwide studies of suicidal phenomena in adolescence and found that a median of 7 to 10 per cent of adolescents had made a suicide attempt. Moscicki (1989) conducted a small review of community-based studies of suicidal phenomena in adults; both Moscicki and Safer reported that many differences in findings between studies could be attributed to differences in methodology, supporting de Wilde and Kienhorst's (1994) conclusions. In addition, Safer noted that the refusal rate for anonymous questionnaires was substantially lower than for non-anonymous methods of assessing the prevalence of suicidal behaviour. The refusal rate is likely to influence how representative a sample is with respect to the population from which it is drawn. Therefore anonymous studies are likely to include a more representative sample and hence provide a more accurate measure of the prevalence of deliberate self-harm.

Recently, de Wilde (2000) presented a general population perspective on adolescent suicidal behaviour, reviewing the findings from several community-based studies. In addition to the characteristics previously identified as being associated with suicidal phenomena, de Wilde notes that the "extent to which many of the studies include representative samples of adolescents is uncertain" and therefore the prevalence figures from these studies should be treated with caution. Some correlates of adolescent suicidal behaviour in general population studies are identified but de Wilde did not attempt to provide a definitive account of such correlates.

The demographic characteristics of the population studied and the research methodology employed clearly have an impact on the reported prevalence of suicidal phenomena. The two reported reviews on population-based studies of suicidal phenomena in adolescents were both somewhat limited. First, de Wilde and Kienhorst's (1994) review focused solely on the results of studies in one country, The Netherlands; and, secondly, Safer's (1997) review did not include non-English language publications and the effect of age, gender and ethnicity on the prevalence figures for deliberate self-harm was not examined in detail. It was also restricted to studies reported in the medical literature (Medline and Index Medicus). As many population-based studies are conducted within schools, some may be reported in educational research literature. A further reason for a new review is that because of growing awareness of suicidal phenomena in the young a substantial amount of further research

has been conducted in the past few years which would not have been included in either of the earlier reviews. Finally, until now no attempt has been made to provide a complete overview of the characteristics of adolescents and their backgrounds and circumstances which are associated with adolescent suicidal phenomena.

Suicidal behaviour has become more common in young people and suicide is now the second or third most frequent cause of death among 15 to 24 year-olds in several countries. General population epidemiological surveys of adolescents can provide valuable information about suicidal phenomena. This includes accurate community prevalence figures for both suicidal thoughts and suicidal behaviours. Also, the characteristics of adolescents who self-harm or have suicidal ideas can be defined. This can assist in the early identification of 'at risk' adolescents and inform both prevention and intervention strategies.

Method

Searches of several electronic literature databases were carried out using search terms to retrieve articles, including those in non-English languages, that reported studies of the prevalence of suicidal phenomena in adolescents in the general population. Relevant references were retrieved and their references were scanned for other possible articles. Several internet sites were searched and two experts in the field were asked to review a provisional reference list and to advise us of any studies, published, unpublished or in-progress, which had not been identified.

We included studies in the review if they met the following criteria: a prevalence figure for suicidal phenomena was reported; study participants had answered either a self-report questionnaire about suicidal phenomena, or similar questions presented at interview; the majority (90 per cent or over) of the participants were between 12 and 20 years old (inclusive); and the study sample was population-based.

Studies were grouped according to the type of suicidal phenomena which were investigated, the time-frames covered and the survey methods employed. With regard to actual behaviours, we categorised the studies into two groups:

- attempted suicide: death was the intended outcome of the behaviour, - for example, 'tried to kill yourself' and 'attempted suicide'; and
- deliberate self-harm: death was not necessarily the intended outcome for example, 'tried to hurt or kill yourself'.

With regard to suicidal thoughts, 'casual thoughts' about suicide, for example "thought about death or dying", were not considered as indicative of suicidal tendencies as they do not necessarily indicate that the person was thinking of carrying out a suicidal act themselves. They were therefore not included in this review. More serious thoughts were categorised into three groups: suicidal thoughts, suicide plans, and suicide threats. For the purpose of this review the time-frames were categorised as follows: lifetime, past year, past six months, past month, and recent.

The results are reported in three sections:

1. **Overview:** An overview of all the studies included in the review is presented and this is followed by a summary of the prevalence figures for suicidal phenomena from these studies.
2. **Meta-analyses:** Meta-analyses of the results of the studies were conducted to identify whether any methodological aspects of the studies and/or demographic characteristics of the sample contributed to the variation in the reported prevalence of suicidal phenomena.
3. **Correlates of suicidal phenomena:** A review of the possible risk and protective factors for suicidal phenomena is presented. This involved comparing the quantity of evidence in support of an association versus the quantity of evidence against such an association, and also appraisal of the role of factors investigated in multivariate analyses.

Key Findings

One-hundred-and-twenty-eight studies¹ were identified through the search strategies as eligible for inclusion in the review. The studies comprised 513,188 adolescents. The mean number of participants per study was 4,009, and the median number of participants was 1016. Thus most studies tended to include relatively small samples for examining what are generally infrequent phenomena. The vast majority of the included studies were conducted in North America, largely in the USA. Most other studies were conducted either in Europe or Australia/New Zealand. Very few studies were conducted in other regions.

Suicidal thoughts and behaviours appear to be relatively common in adolescents in the general population. A mean of 10 percent of adolescents reported that they had engaged in suicidal behaviour (e.g. 'attempted suicide') at some point in their lives. The proportion of adolescents who reported engaging in deliberate self-harm at some point in their lives was higher than for suicidal behaviour, with a mean of 14 per cent. Thirty percent of adolescents said that they had thought about suicide at some point in their lives, including 19 per cent in the past year. The proportion of adolescents reporting having made suicide plans and threats was lower than those reporting having had suicidal thoughts, but higher than the proportion reporting suicidal behaviour and deliberate self-harm.

Suicidal Phenomena	Mean Prevalence
Suicidal behaviour	10
Deliberate self-harm	14
Suicidal thoughts	19

Table 1. The lifetime prevalence of suicidal phenomena

¹ For four studies of the 124 studies included in this review the results were reported separately for sub-groups of the sample, as though they were different studies, giving 128 studies.

There was considerable variation in the extent to which adolescents reported suicidal behaviours and thoughts. For example, the proportion of adolescents reporting lifetime suicidal behaviour varied between 2 per cent and 30 per cent, and those reporting lifetime suicidal thoughts varied between 8 per cent and 70 per cent.

Meta-analyses

There is some evidence to suggest that the prevalence figures for suicidal phenomena are influenced by the survey method used. Thus reported prevalence was somewhat higher in studies that employed anonymous questionnaires than in studies using other methods but many of the differences were not found to be significant in within-group meta-analyses. However, there was considerable variation between the findings of studies even when both the same methods of assessment of suicidal phenomena and questionnaire administration were employed. This indicates that factors additional to method of administration may have an influence on the reported prevalence of suicidal thoughts and behaviours. There was little evidence of an association between the quality of a study (in terms of sample size, representivity and response rate) and the reported prevalence.

In the vast majority of studies the prevalence of suicidal phenomena was higher in females than males. Within-study meta-analyses were conducted and for most of the categories of suicidal phenomena female gender was found to be significantly associated with an increased risk of both recent and previous suicidal thoughts and behaviours. The rates of suicidal phenomena in females were at least 1.25 times higher than those in males, and, for suicidal behaviour in the past year, the rate in females was more than two times higher than that in males.

There was little evidence to suggest that suicidal phenomena vary between the ages of 12 and 20 years. However, there were methodological factors in this review that may have masked any age differences that have previously been shown in hospital-based studies.

There is some evidence that the prevalence of suicidal phenomena varies between countries, although in the meta-analyses not all differences were found to be significant. Generally, the prevalence was higher in North America than in Europe, Mexico and Asia, but there was no difference between the findings for North America and Australia/New Zealand.

The prevalence of suicidal phenomena differed between ethnic groups. Overall, rates appeared to be higher in Native American and Hispanic adolescents than in both Black and White adolescents, but many of these differences were not significant in the meta-analyses. Significant differences only tended to be reported in those studies with relatively large sample sizes, suggesting that non-significant findings may be the result of insufficient power.

Factors associated with suicidal phenomena

The results concerning factors associated with suicidal phenomena were investigated in a simplistic manner to provide an overview of the results and identify any clear trends. Correlates of suicidal phenomena were considered in four areas, each assessing associations related to a specific life domain. The key findings are summarised below:

- Physical and mental health and well-being

- Mental health difficulties were generally associated with suicidal phenomena.
- There was particularly strong evidence for a direct association between suicidal phenomena and depressive symptoms (including hopelessness) and disorders.
- There appeared to be an association between behavioural problems and suicidal phenomena, particularly in females.

- Other personal characteristics and experiences

- The association between sexual orientation and suicide attempts was investigated in only one study. Homosexual orientation in both genders and bisexual orientation in females was associated with attempted suicide.
- Physical and sexual abuse both appear to be strongly associated with suicidal phenomena, and in multivariate analyses these associations appear to be direct.
- Exposure to suicide in others was associated with an increased risk of suicidal phenomena.

- Family characteristics

- Overall, there does not appear to be an association between socio-economic characteristics of the family and suicide phenomena.
- Good communication with, and feeling understood by family members is associated with a lower prevalence of suicidal phenomena. The results from multivariate analyses indicate that this relationship is not direct.
- Conflicts and arguments within the home are associated with an increased prevalence of suicidal phenomena. Family harmony and cohesion appear to protect against suicidal phenomena. This association appears to be stronger for females than males and the relationship is likely to be direct.

- Social factors

- There was an association between suicide attempts and both poor academic achievement and poor school attendance. Both these associations appear to be indirect.
- Good peer relationships were associated with a decreased prevalence of suicidal thoughts but the relationship with suicide attempts is unclear.
- Lack of communication with others about personal difficulties and problems was directly associated with an increased prevalence of suicidal phenomena.

Conclusions

This review of the world literature has demonstrated that suicidal phenomena are a significant problem in adolescents. In much of the research on adolescent suicidal behaviour, estimates of the prevalence of suicide attempts have been based on evidence from studies of hospital presentations. It is clear that such studies are likely to substantially underestimate the true rate of deliberate self-harm as many adolescents who receive medical attention for a self-harm act report previous episodes which have not resulted in medical attention. The findings from general population studies in which information has been obtained on whether or not self-reported acts of deliberate self-harm or attempted suicide result in hospital presentation suggest that at least three or four times as many adolescents engage in deliberate self-harm compared to the numbers who receive medical attention as a result of the acts.

The data presented in this review indicate a likely association between survey methods and the rates of suicidal phenomena in that a larger proportion of adolescents gave positive responses to anonymous questionnaires than where non-anonymous survey methods were employed.

The results also show that many demographic, personal, family and social characteristics are associated with suicidal phenomena in adolescence. Most of these associations are in line with the findings from studies of adults and hospital-based studies of adolescents. Mental health problems were associated with suicidal phenomena, and there was particularly strong evidence for a direct association between depressive symptoms and suicidal phenomena. Both physical and sexual abuse were associated with an increased risk of suicidal thoughts and behaviours, as was exposure to suicide in others. Unlike in adults, risk of suicidal phenomena does not appear to reflect the socio-economic characteristics of the families of adolescents. This finding is in keeping with the studies of adolescents attending hospital as a result of suicide attempts. Poor family relationships (including poor communication and emotional relationships and family discord) were associated with an increased risk of suicidal phenomena. Several categories of school related variables appeared to be associated with suicidal phenomena: namely, poor academic achievement, poor school attendance, having a negative attitude towards school and school work and school misconduct.

In conducting this review, several issues were identified which could inform future research. Specifically, the terminology and time-frame used in the assessment of suicidal phenomena should be selected carefully. Some reasoning for the choice of terminology would be informative for other researchers. Asking adolescents to provide a description of their self-harm episodes or suicide attempts could provide valuable evidence as to whether or not they have correctly interpreted the question and whether the acts fit the investigators' criteria. Researchers should also clearly state the timeframe over which the behaviour is being assessed as this will impact on the prevalence of suicidal phenomena. In addition, researchers should be aware of the impact of different response categories in that social acceptability of answers may vary according to the categories provided. Differences in the method of assessment of suicidal phenomena must be borne in mind when making cross-study comparisons. Researchers should conduct power analyses to determine how many adolescents should be included in studies to produce reliable figures for suicidal phenomena and to establish whether differences exist between adolescents experiencing suicidal thoughts or behaviours and other adolescents. Furthermore, the anticipated prevalence of independent variables should be taken into

account when conducting these power analyses. Attempts to overcome the problem of reporting bias should be made by providing details of all the dependent variables which are entered into the analyses, including the ones with non-significant findings.

The prevalence figures for suicidal acts and thoughts in adolescents identified in this review show that these represent a significant issue which needs to be addressed. The associated or 'risk' factors indicate specific targets for attention as well as the characteristics of adolescents who may be at risk. The finding that adolescents who are experiencing academic and behavioural difficulties in school have higher rates of self-harm than their peers indicates that early prevention strategies, which often involve parents and aim to improve performance and/or behaviour in school, may also have an impact on adolescents' mental health and reduce suicidal phenomena. Poor mental health, and especially symptoms of anxiety and depression, were found to be strongly associated with suicidal phenomena and should be addressed in any prevention strategy. The importance of exposure to suicidal behaviour in peers as a risk factor indicates that professionals who are involved with adolescents in schools and other settings must be aware that a suicide or suicide attempt may necessitate specific interventions. This could include open discussion of the behaviour, including other ways of coping, and provision of appropriate support mechanisms for other individuals who may be at risk.

Introduction and overview of the study

This school-based study investigated the prevalence of deliberate self-harm and suicidal thoughts, and the factors associated with them, in a large representative community sample of young people aged 15 and 16 years. The study is the first of its kind to be conducted in England and the findings will be important in defining the extent of the problem of deliberate self-harm and suicidal thoughts in adolescents, identifying the factors that need to be addressed in preventing and managing this and determining how Samaritans and other agencies target help for this population.

The following were the aims of the study:

1. To determine the prevalence of deliberate self-harm and suicidal thoughts in a large representative sample of adolescents.
2. To identify the risk factors for deliberate self-harm and suicidal thoughts in adolescents.
3. To explore the coping strategies generally used by adolescents, especially those of adolescents who self-harm or who have suicidal thoughts.
4. To investigate whether such adolescents (and others not currently at risk) have contacted or would contact Samaritans or other helping organisations, and if not, what impedes their using these widely available sources of help.

Methodology

This study is based on an anonymous self-report survey of the lifestyle and coping skills of adolescents. Anonymous questionnaires are particularly suited to collecting sensitive data. Shochet and O’Gorman (1995) and Safer (1997) suggest that it is likely that someone who would admit to suicidal thoughts or behaviours anonymously would not do so if such an admission would lead to their identification. In addition, Saunders et al (1994) highlight the fact that the validity of adolescents’ self-report data gathered by anonymous questionnaire has been established, especially for conditions of emotional distress. Furthermore, there is broad consensus that self-report information is critical when examining adolescents’ emotional health (Weissman et al 1980).

The lifestyle and coping skills questionnaire was developed with colleagues who have extensive experience of school-based studies. It was piloted on three different groups:

- A ‘normal’ sample of school children from a school in London
- A sample of adolescents with psychiatric problems from a psychiatric unit for adolescents in Oxford
- A focus group conducted in a school using a group of mixed ability pupils who were asked to comment on all aspects of the questionnaire

Schools taking part in the study were from Oxfordshire, Northamptonshire and Birmingham. They were chosen to provide as representative a sample as possible in terms of gender (single sex and co-educational), size, type (state, grammar and independent), educational achievement (based on

school GCSE performance), socio-economic deprivation (based on proportions of pupils entitled to free school meals) and ethnicity. Where a school declined to take part, a matched replacement school was approached. Forty-one schools were included in the study which took place in the Autumn and Spring terms of 2000 and 2001. There were 35 state, four independent and two grammar schools in the study.

The pupils who took part were in classes where at least 90 per cent were aged 15 and 16 years.

The design of the study was in keeping with the guidelines published by the British Educational Research Association (1999). A full explanation of the purpose was given to teachers in participating schools. Letters were sent to all parents of pupils in the relevant classes, informing them of the project and asking them to notify the research team if they objected to their children taking part. Pupils were informed in advance about the study either by a member of the research team or staff at their school. They were told that those who did not want to take part did not need to do so.

The questionnaire was completed in class, in silence, under exam conditions. A member of the research team was on hand to answer any queries raised by the pupils. Teacher involvement was kept to a minimum to reassure pupils of the anonymous and confidential nature of the questionnaire.

Results Part One and Part Two

Sample of schools and pupils

All pupils in the relevant classes in the 41 schools that participated in the study were invited to take part. A total of 6020 out of 7,433 potential pupils did so. Reasons for non-participation included: parental opt-out (N = 139), student opt-out (N=23) and absentees (N = 1243) (Figure 1).

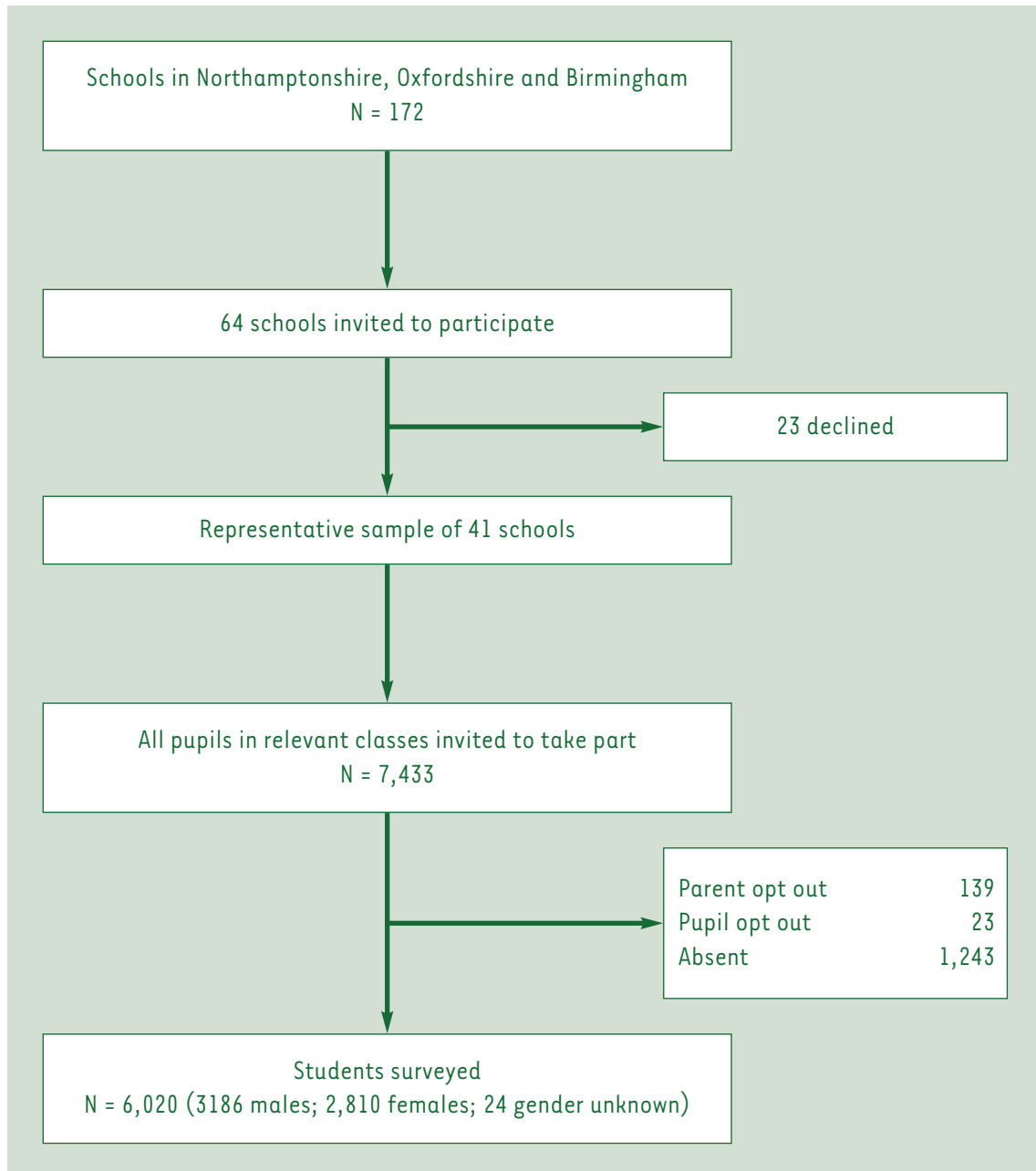


Figure 1. Selection of sample

The participants recorded their ethnic status as illustrated in Table 2. The distribution within the sample was very close to the figures for England (Department for Education and Employment 1999), except for a higher representation of Asian individuals.

	White N (per cent)	Black N (per cent)	Asian N (per cent)	Other* N (per cent)	Unknown N (per cent)	Total N (100 per cent)
Males	2604 (81.7)	71 (2.2)	400 (12.6)	79 (2.5)	32 (1.0)	3186
Females	2348 (83.6)	96(3.4)	271 (9.6)	77 (2.7)	18 (0.6)	2810
Unknown	4	2	0	1	17	24
Total	4965 (82.3)	169 (2.8)	6711 (11.1)	157 (2.6)	67 (1.1)	6020
Data for England (percent)	(88.5)	(3.1)	(6.2)	(2.2)	-	-

*The category 'Other' largely consists of those pupils who describe themselves as being of mixed race (60 per cent). Other descriptions included Mexican, Egyptian and Jamaican.

Table 2: Characteristics of the sample.

The majority (69.6 per cent) of the pupils were living with both parents, 15.1 per cent lived with one parent, 11.7 per cent with one parent and a step-parent, 1.1 per cent were living with another family member, and 1.0 per cent were living with someone else.

Prevalence figures

In this report we focus on three groups:

- Pupils who had engaged in deliberate self-harm in the previous year;
- Pupils who had had suicidal thoughts (thoughts of self-harm) but had not engaged in deliberate self-harm; and
- Pupils who reported neither deliberate self-harm nor suicidal thoughts.

The pupils who reported deliberate self-harm were asked to provide a description of the act or the most recent one if there had been multiple episodes. The prevalence of deliberate self-harm was based on applying strict criteria to the pupils' descriptions of their acts. This approach has not, to the authors' knowledge, been used in previous studies. This approach would have slightly underestimated the true prevalence, as some pupils did not supply a description. It would however, be more accurate than the figures reported in most other studies.

Pupils with deliberate self-harm		
	Self-report	Based on deliberate self-harm description
Lifetime	13.2	10.3
Past Year	8.6	6.9
Past Month	3.1	2.5

Pupils with suicidal thoughts, but no deliberate self-harm in the previous year

15.0 per cent

Pupils with no suicidal thoughts or behaviour in the previous year

72.8 per cent

Table 3: Prevalence of deliberate self-harm and suicidal thoughts.

The prevalence figures for deliberate self-harm, before applying our criteria, of 8.6 per cent (previous year) and 13.2 per cent (lifetime) are in keeping with those of similar studies from elsewhere, such as the Center for Disease Control in the USA (1990). They are somewhat higher than the findings of a recent study in England based on interviews with adolescents and their parents (Meltzer et al, 2001). The 15.0 per cent previous year prevalence of suicidal ideas without self-harm indicates that these translate into actual behaviour in a minority of cases (Table 3).

Hospital Presentation

Deliberate self-harm is clearly far more frequent in adolescents than is indicated by general hospital presentations in that hospital referral occurred for only 12.6 per cent of episodes that met the study criteria and had occurred in the previous year. This is probably due to self-poisoning, which is more likely to lead to hospital presentations, being far less frequent than self-injuries, especially minor self-cutting, which was the most frequent method of self-harm. Of those who self-harmed in the previous year 64.6 per cent reported that they had engaged in self-cutting and 30.7 per cent reported self-poisoning.

Gender differences

The nearly four-fold higher rate of deliberate self-harm in the previous year in females compared to males (Figure 2) is not dissimilar to the gender difference in hospital-based rates in this age-group (Sellar et al 1990, Hawton et al, 2000).

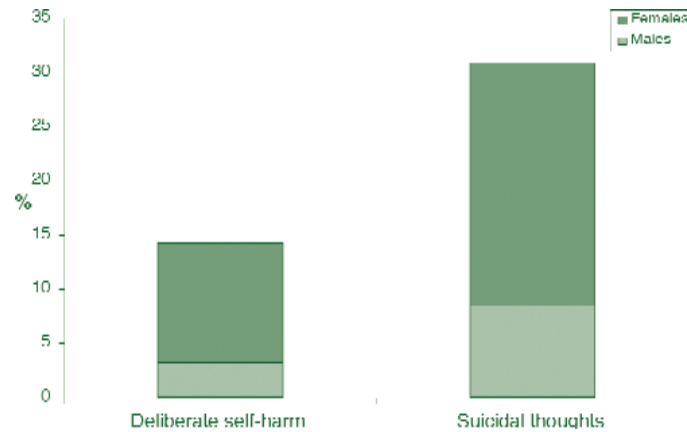


Figure 2. Prevalence of deliberate self-harm and suicidal thoughts by gender (previous year).

Ethnic differences

Deliberate self-harm was common in the White pupils (Figure 3). Although those who defined themselves as belonging to the 'Other' ethnic group were a relatively small proportion of the sample, they also had high rates of deliberate self-harm. This group consists mainly of those pupils who describe themselves as being of mixed race (60 per cent). Other descriptions offered by the pupils included 'Mexican' and 'Jamaican'. Suicidal thoughts were most common in White pupils.

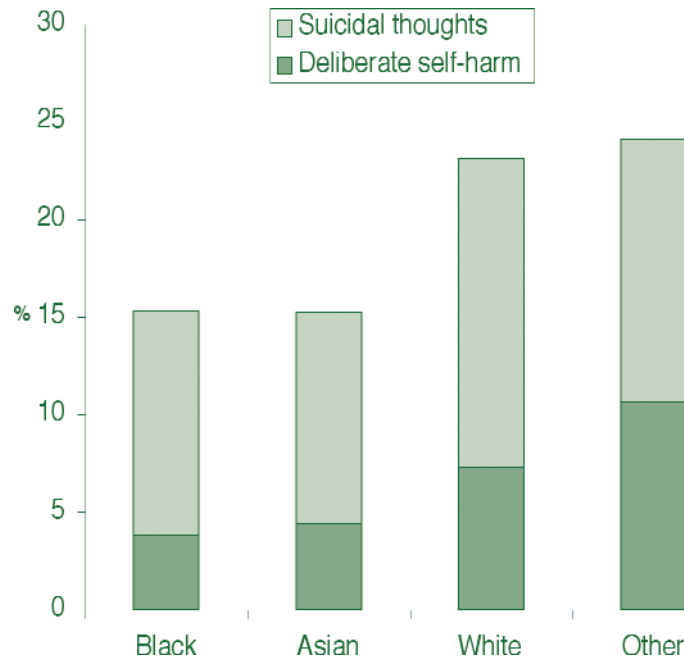


Figure 3. Prevalence of deliberate self-harm and suicidal thoughts by ethnicity (previous year).

Methods of deliberate self-harm employed in the previous year

Self-cutting (n=257) and overdose (n=122) were the two most common methods used by males and females. Figure 4 shows that both methods were proportionately more common in females than males. Other methods of deliberate self-harm included self-battery (n=16), use of recreational drugs (n=15), use of alcohol (n=10), hanging (n=4) and suffocation (n=2).

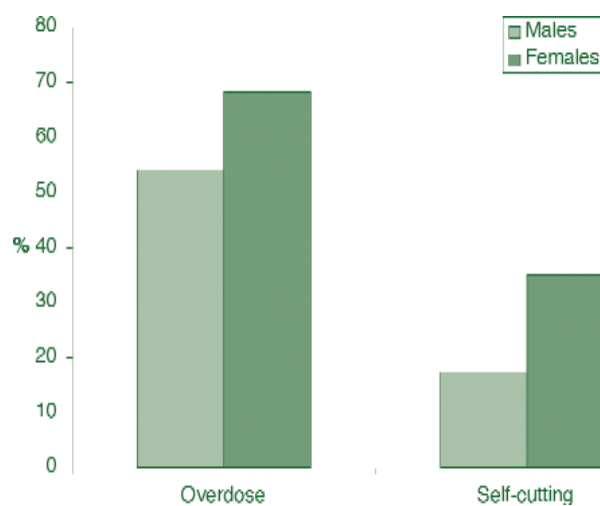


Figure 4. Prevalence of overdose and self-cutting in the previous year amongst those reporting deliberate self-harm.

Reasons given for engaging in deliberate self-harm

The two most common reasons offered by both males and females for engaging in deliberate self-harm was that they did so to find relief from a terrible state of mind or because they had wanted to die (Figure 5). Although the trend in choice of reason was very similar for both genders, females indicated more reasons than males.

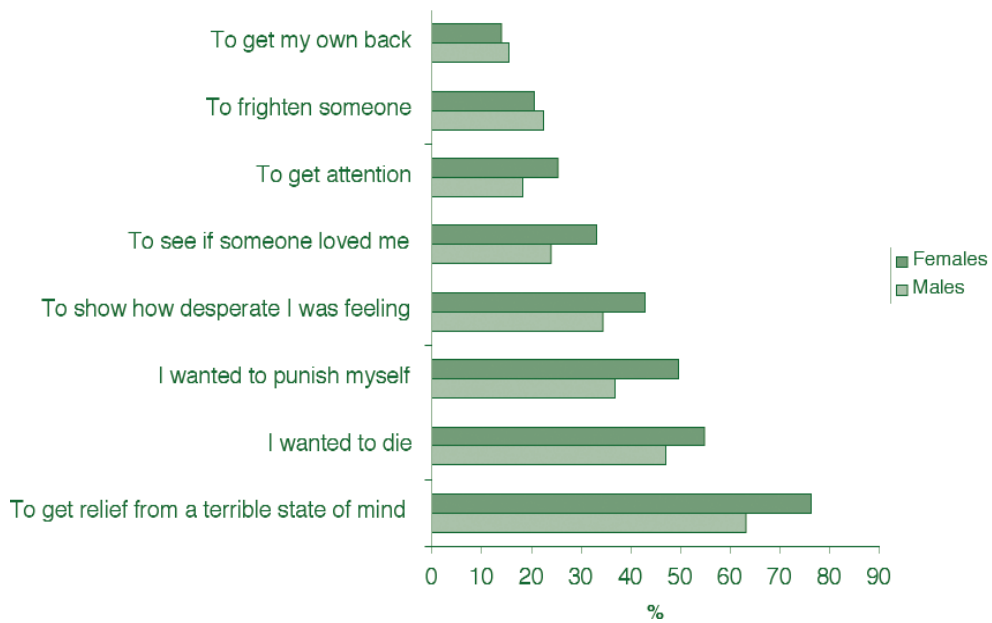


Figure 5. Reasons given for engaging in deliberate self-harm in the previous year, by gender.

Help Seeking

Did pupils try to get help before engaging in deliberate self-harm?

Figure 6 shows that friends were the most frequent source pupils sought help from before engaging in deliberate self-harm (40.8 per cent). Other potential sources of help were rarely approached.

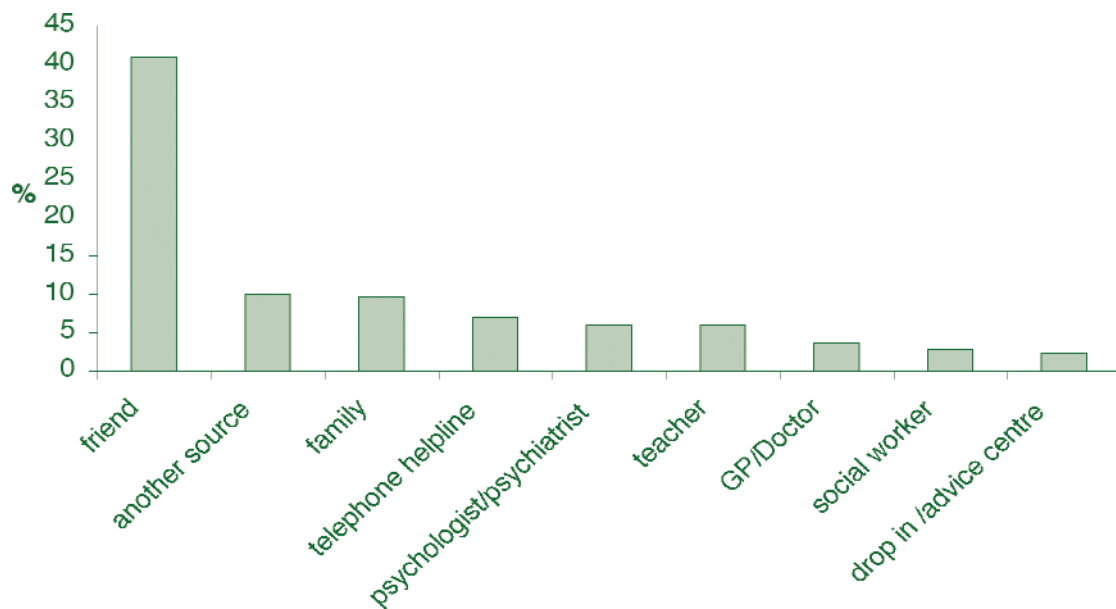


Figure 6. Sources pupils sought help from before their deliberate self-harm episode in the previous year.

Did pupils try to get help after engaging in deliberate self-harm?

Although pupils were not specifically asked to identify who they had sought help from after engaging in deliberate self-harm, they were asked if they had sought help of any kind. 22.1 per cent reported that they had tried to get help afterwards for the problems that led to them taking an overdose or harming themselves.

Pupils were asked to identify who they had received help from. Two sources were most commonly cited: 49 per cent reported that they received help from their friends and 21 per cent from their family.

Experience of life events and problems

Pupils reported problems and life events they had experienced in the previous year. Figure 7 shows the percentage of pupils who reported the events in the previous year among those with deliberate self-harm, those with suicidal thoughts and those with neither. The figure shows that those with deliberate self-harm had experienced more problems and life events than those who reported suicidal thoughts, and those with suicidal thoughts had experienced more problems and life events than those with neither deliberate self-harm or suicidal thoughts.

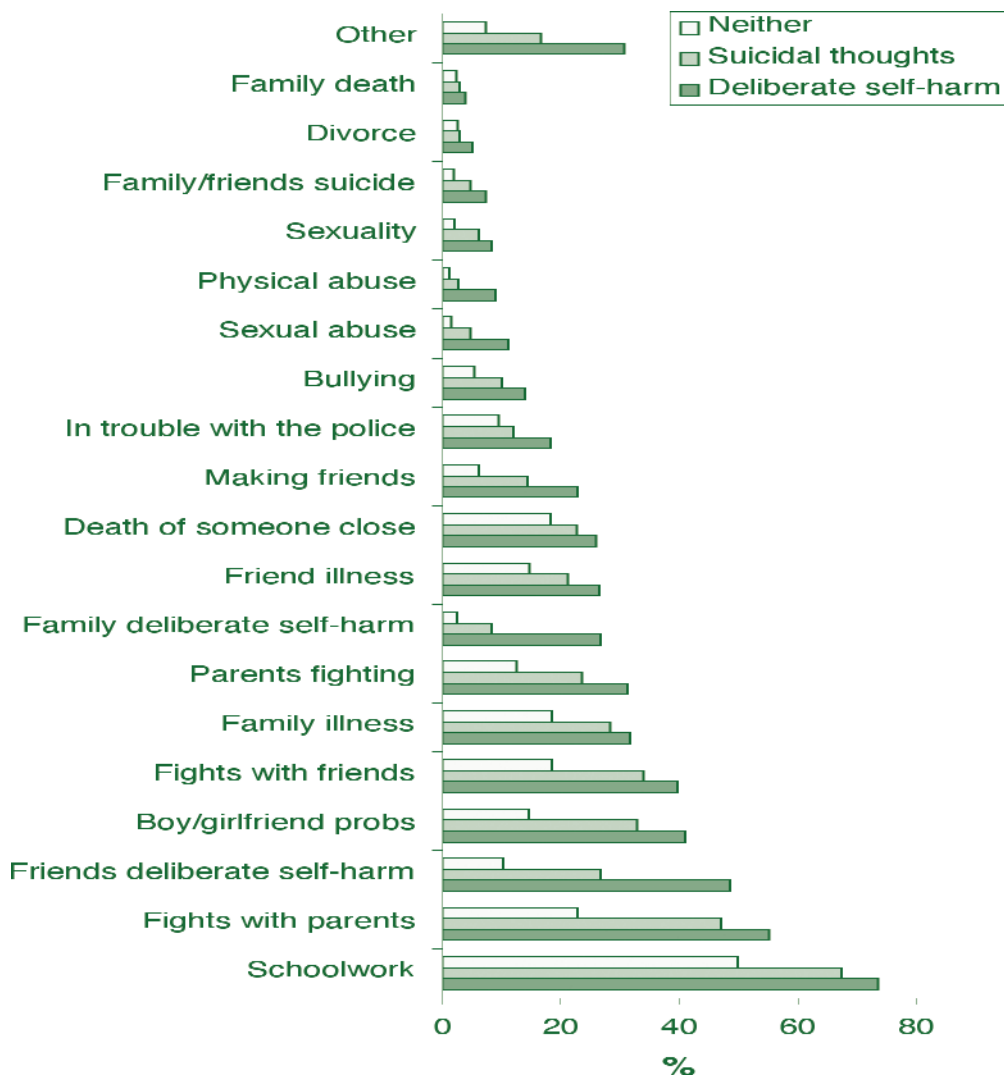


Figure 7. Prevalence of life events and problems.

Anxiety, depression, self-esteem and impulsivity

Pupils answered questions concerning their current levels of anxiety, depression, impulsivity and self-esteem. Clear differences in their scores can be seen in Figure 8. Those pupils who reported self-harm were more anxious and depressed and had lower self-esteem than those who did not. Those with suicidal thoughts were more anxious and depressed and had lower self-esteem than those who did not report such ideas. Pupils who reported self-harm and those who reported thoughts were more impulsive than those who did neither.

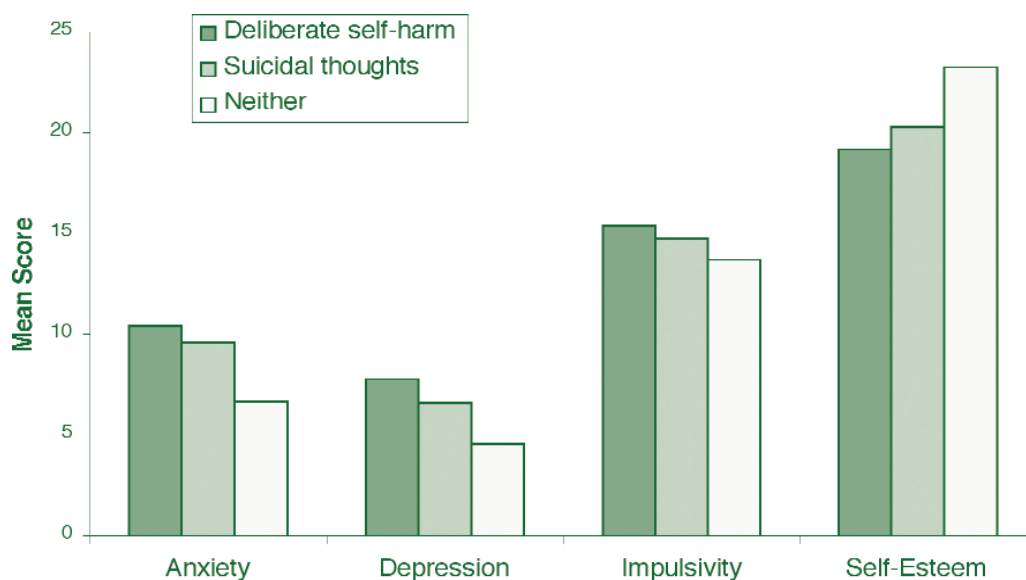


Figure 8. Anxiety¹ Depression¹ Impulsivity¹ and Self-Esteem² scores by self-harm group.

1 The higher the score, the more depressed / anxious / impulsive the group.

2 The higher the score the better the self-esteem.

Factors associated with suicidal thoughts and deliberate self-harm

Using models from logistic regression analyses, the factors that were independently associated with suicidal thoughts and deliberate self-harm were identified (Table 4). While associations from a cross-sectional study cannot be interpreted as necessarily indicating risk factors (longitudinal study being required to verify these), the multivariate analyses indicate the specific factors that are likely to be important.

	Suicidal thoughts		Deliberate self-harm	
	Males	Females	Males	Females
Having friends who have engaged in suicidal behaviour	•	•	•	•
Family member had engaged in suicidal behaviour	-	-	•	•
Smoking	-	•	-	-
Drug use	-	-	•	•
Drunkenness in the previous year	•	•	-	-
Sexual orientation	-	•	-	-
Physical abuse	•	-	-	-
Depression	-	-	-	•
Anxiety	•	•	-	•
Low self-esteem	•	•	•	•
Impulsivity	-	-	-	•

Table 4: Factors associated with suicidal thoughts and deliberate self-harm in the previous year.

While some factors were associated with both suicidal thoughts and deliberate self-harm, others were not. There were also some differences between the genders (Table 4). Having friends who had themselves carried out acts of deliberate self-harm was an important factor for both suicidal thoughts and deliberate self-harm, and in both genders. This is in keeping with other evidence on 'contagion' of suicidal behaviour in adolescents, including clustering of suicides in the young (Gould, Wallenstein and Davidson, 1989). Thus exposure to deliberate self-harm or even suicide by peers may have a modelling effect in some adolescents who are themselves facing problems, resulting in possible suicidal thoughts and the risk of self-harm. Such an effect is well recognised, for example, in various types of institutions for adolescents (Hazell, 1993). Having a family member who had had an episode of self-harm was, however, only related to actual self-harm in the pupils. Thus exposure

to the behaviour in family members may lower the threshold for a similar act, but not actually contribute to suicidal thoughts.

Smoking was only associated with suicidal thoughts in females. While drunkenness was linked with suicidal thoughts, it was not associated with actual self-harm. On the other hand, drug-use was just associated with self-harm. Pupils who had had recent concerns about sexual orientation were likely to have had suicidal thoughts, but this only applied to females. This is an issue which has received little attention in previous community-based studies. Physical abuse was associated with suicidal thoughts in males.

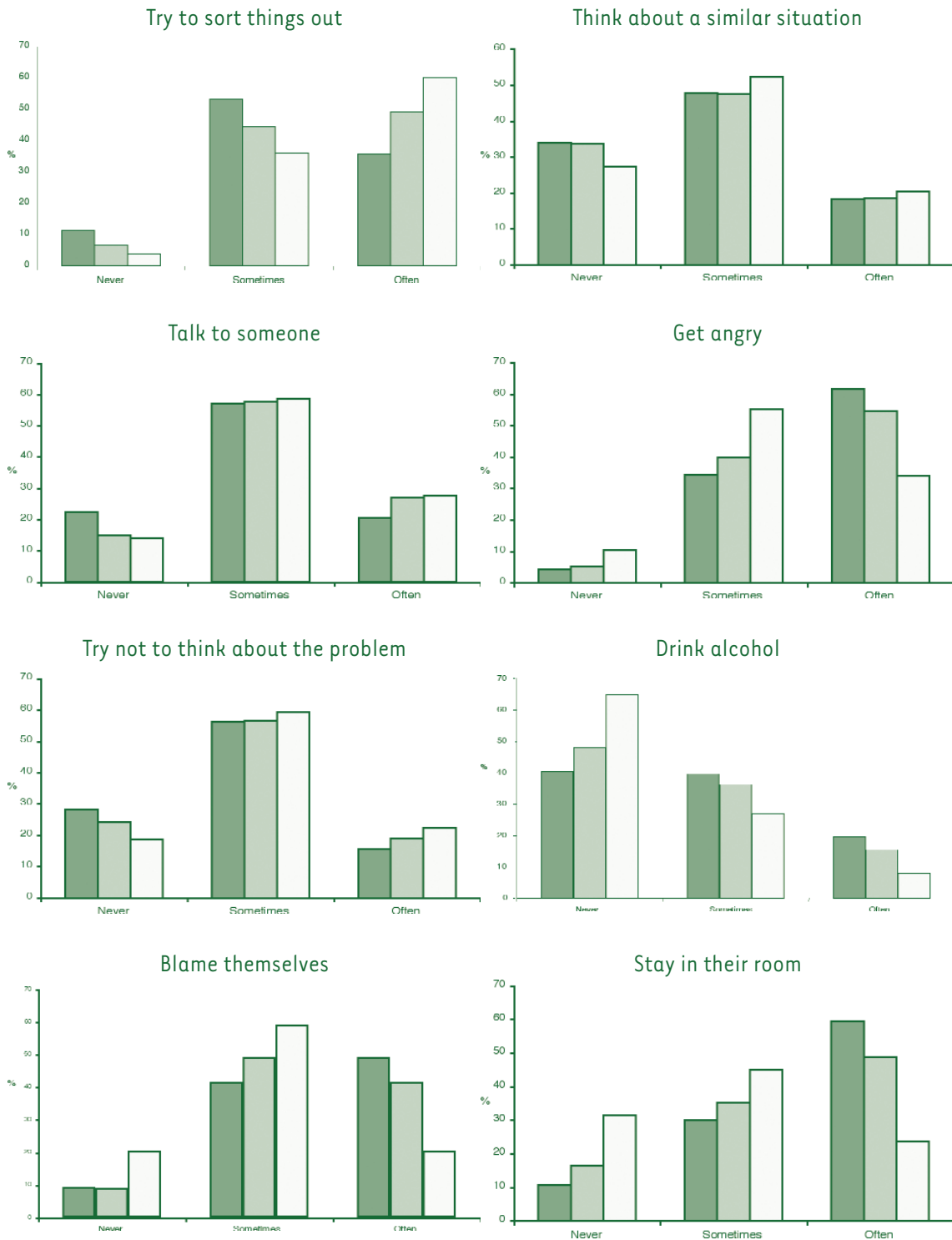
Low self-esteem was linked to both suicidal thoughts and self-harm in both genders. The importance of low self-esteem in this regard in adolescents has also shown in adolescents who present to hospitals after deliberate self-harm (Kingsbury et al 1999). Anxiety levels were also related to both suicidal thoughts and self-harm, but the latter only applied to females. Both levels of depression and impulsivity were associated with deliberate self-harm in the females. The importance of depression and anxiety in adolescent suicidal behaviour has been highlighted by studies of both adolescents with self-harm who present to general hospitals (Kerfoot et al, 1996; Burgess et al, 1998) and in adolescent suicides (Brent et al, 1993; Shaffer et al, 1996).

Coping strategies

Pupils answered a series of questions designed to ascertain how well they coped when they were feeling worried or upset. Figure 9 shows the scores on the individual coping items. Those who engaged in deliberate self-harm were less likely to use positive coping strategies such as talking to someone or trying to sort out the situation. They were more likely to use more negative coping strategies such as blaming themselves, staying in their room, getting angry and drinking alcohol.

Figure 9. Coping strategies used by pupils when worried or upset.

Deliberate self-harm Suicidal thoughts Neither



Communication strategies

Pupils were asked to indicate who they felt they could talk to about things that really bothered them. They were able to tick more than one response. This allowed us to create a score of the number of people pupils felt that they could talk to. Figure 10 shows that those who had not engaged in deliberate self-harm or who had just had suicidal thoughts were able to talk to more people than those who had engaged in deliberate self-harm.

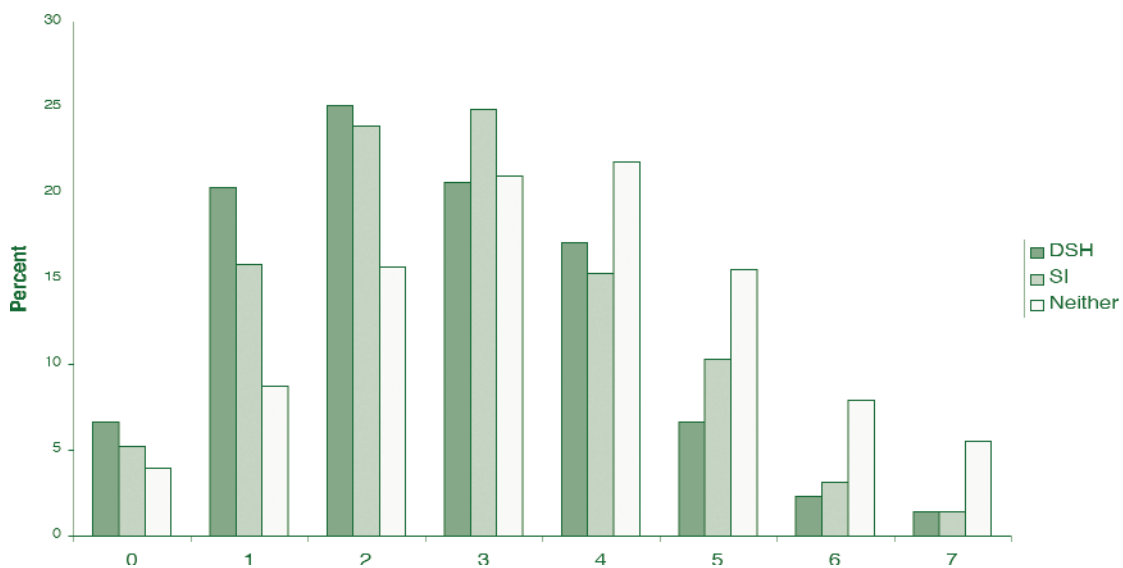


Figure 10. Number of people pupils felt able to talk to.

In terms of whom pupils felt they could talk to about things that really bothered them, all three groups were equally likely to feel that they could talk to a friend. However, the general trend (Figure 11) was for those who reported deliberate self-harm and those who had had suicidal thoughts to be less likely to be able to talk to the other people listed when compared to those with no suicidal behaviour. Only 20.5 per cent of all pupils felt that they could talk to a teacher about something that was really bothering them.

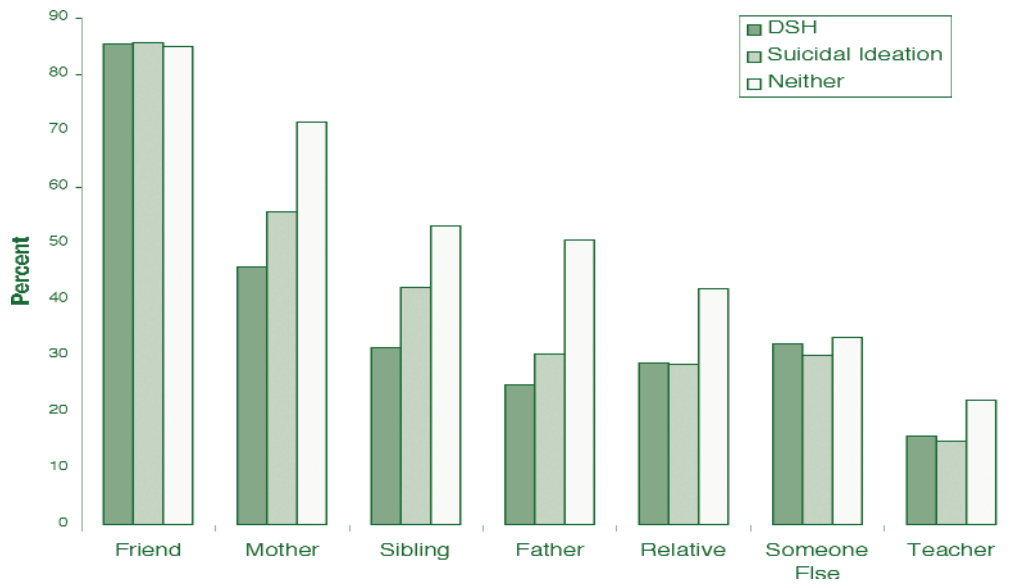


Figure 11. People adolescents felt able to talk to about things that really bothered them.

Since young people clearly see their peers as a key source of support, important questions are whether they are able:

- a) to recognise when friends are having difficulties; and
- b) to provide help, either themselves or through involving other people.

The next section of the report focuses on the pupils' help-seeking behaviours.

Help seeking behaviour

79.4 per cent of the total sample said that they had heard of an organisation called Samaritans (74.8 per cent males and 84.9 per cent females). A total of 101 adolescents (1.8 per cent) had contacted Samaritans and 463 (8.1 per cent) had considered contacting them.

Pupils who had contacted Samaritans

Of the pupils who had contacted Samaritans, 75 had done so by telephone, 19 had emailed them, 18 had gone into a branch to talk to someone face-to-face, and 21 had contacted them by letter. Some adolescents had contacted Samaritans by more than one means.

Pupils who had contacted Samaritans were asked to score how helpful talking with them had been (Figure 12). A score of 1 indicates that talking with them did not help at all, whilst a score of 5 indicates that it helped a lot. The responses varied considerably. While a low number of pupils had found the contact helpful, a substantial proportion did not.

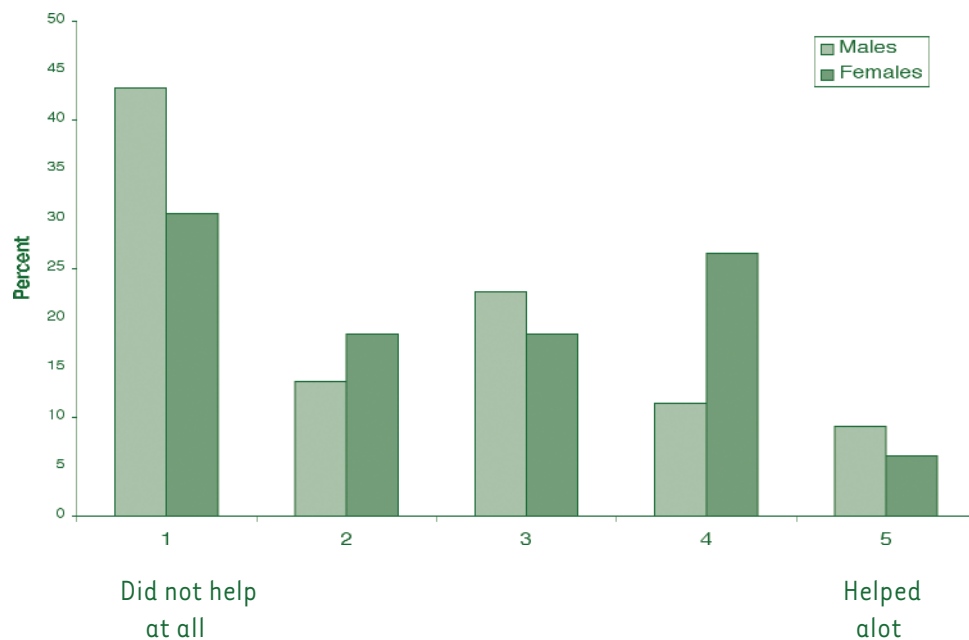


Figure 12. How helpful pupils had found talking to Samaritans

Having rated the help offered to them, pupils were given the opportunity to write any further comments they had. The comments were mixed (Table 5) reflecting the ratings shown in Figure 12.

"It was friendly and not like a teacher speaking. You could actually talk to them."

"They didn't seem interested in what I was saying."

"It was nice to talk to someone who wasn't involved and I needed advice as it wasn't me who needed help."

"They seemed confused and only listened, they didn't give any advice."

"I felt that the people helping me were a lot older so we couldn't really relate. They didn't quite understand the pressures of today's teenagers."

Table 5. Sample of pupils' comments on the helpfulness of talking to Samaritans

Equal proportions of males and females had contacted Samaritans. Nine percent were living apart from their family, which is much higher than for the rest of the sample.

The pupils were asked whether they had experienced any serious personal, emotional, behavioural or mental health problems for which they felt they had needed professional help in the previous year (Figure 13). Of adolescents who had contacted Samaritans, 44.0 per cent did not think they had had serious problems for which they needed professional help. This may, however have reflected a change in their circumstances since they made contact with Samaritans. Twenty-five percent of the pupils who had contacted Samaritans said they had had serious problems and had asked for help, 19.8 per cent had felt the need for help but had not sought it and 11.0 per cent had had serious problems but hadn't felt the need for help.

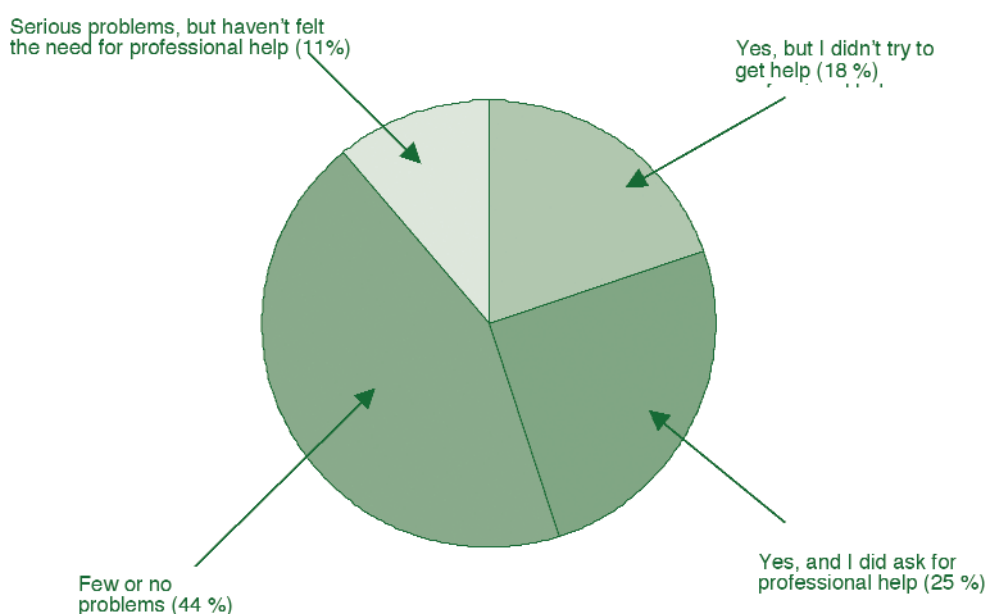


Figure 13. Problems and the need for professional help in pupils who had contacted Samaritans.

Pupils who had contacted Samaritans had experienced an average of eight negative life events of the twenty they were asked about, compared to the remainder of pupils who experienced an average of five negative life events. Most adolescents who had contacted Samaritans had experienced problems keeping up with schoolwork, had had arguments or fights with their parents and friends, or someone else close to them had died. Around 20 per cent had experienced other serious events such as sexual or physical abuse or loss of a friend or family member due to suicide.

On average, females were likely to have experienced nine of the problems asked about whereas males experienced seven. Several problems had been experienced more by the females than the males. The largest differences were for being bullied, having a close friend who had attempted suicide and having problems with friends. Males were much more likely to have been in trouble with the police and to have experienced the death of an immediate family member (Figure 14).

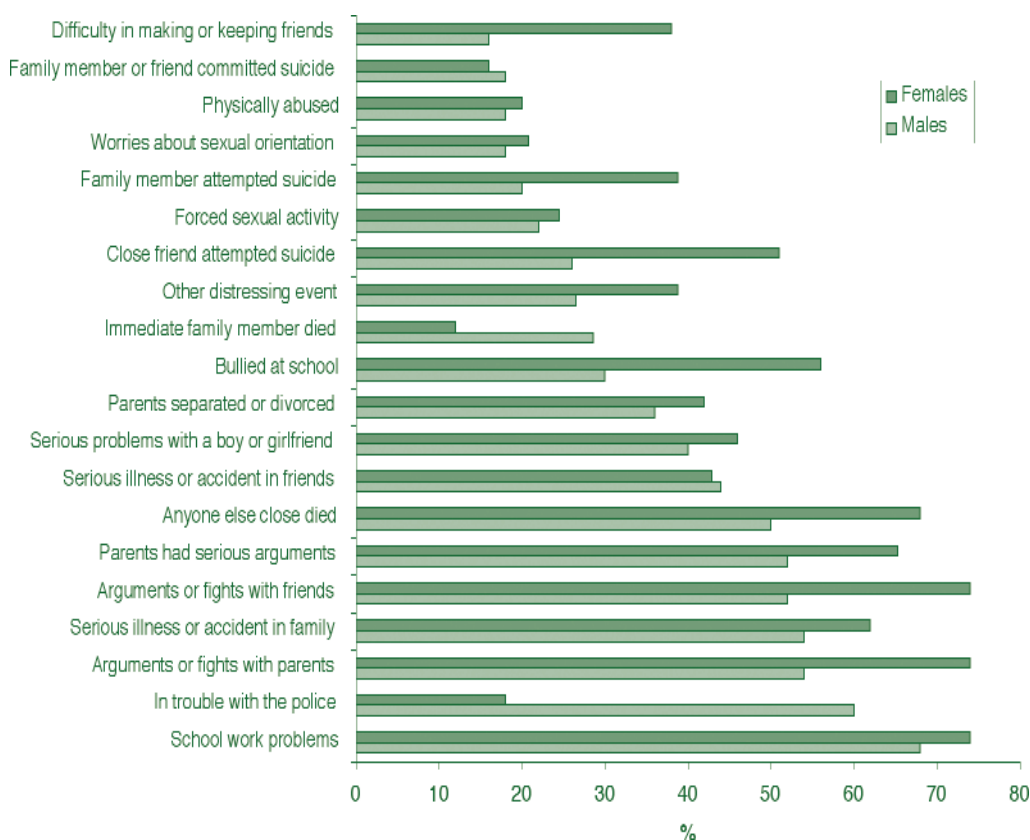


Figure 14. Types of problems facing adolescents who contact Samaritans

Of those adolescents who had contacted Samaritans 19.1 per cent had engaged in self-harm in the past year, compared with 7.0 per cent in the rest of the sample - 30.3 per cent had thought about suicide but hadn't actually engaged in self-harm (compared with 16.3 per cent in the rest of the sample), and 50.6 per cent had neither thought about suicide nor engaged in self-harm. Of the adolescents who had contacted Samaritans, females were more likely than males to have experienced suicidal thoughts or to have self-harmed (Figure 15).

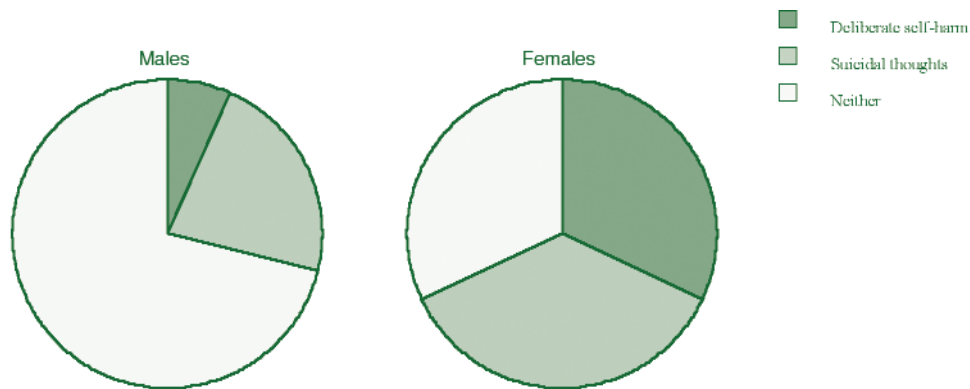


Figure 15. Deliberate self-harm and suicidal thoughts experienced by adolescents who contact Samaritans

As part of the survey adolescents were asked to complete scales which measured depression, anxiety, impulsivity and self-esteem.

DEPRESSION – For adolescents who had contacted Samaritans, the mean depression score was 7.1, suggesting possible depression, while the mean score for the rest of the sample was 5.0. Thus pupils who had contacted Samaritans were more depressed than other adolescents. Males (both those who contacted Samaritans and in the whole sample) generally had lower depression scores than females.

ANXIETY – The mean anxiety score for adolescents who had contacted Samaritans was 9.6, suggesting a possible emotional disorder. The mean anxiety score for the rest of the sample was 7.4. Pupils who had contacted Samaritans were therefore more anxious than other pupils. Males (both those who contacted Samaritans and in the whole sample) generally had lower anxiety scores than females.

IMPULSIVITY – The mean impulsivity score for adolescents who had contacted Samaritans (14.6) differed little from that for the rest of the sample (14.0).

SELF-ESTEEM – The mean self-esteem score for adolescents who had contacted Samaritans (20.8) was somewhat lower than that of the rest of the sample (22.5).

Adolescents were also asked about smoking, drinking and drug taking. A number of adolescents who had contacted Samaritans were heavy smokers (17.6 per cent smoked more than 50 cigarettes per week), drank 11 or more drinks (one drink was defined as being equivalent to half a pint of beer, lager or cider, a glass of wine or one measure of spirits) per week (17.2 per cent), had been drunk more than 10 times in the past year (33.7 per cent) and had tried drugs (Table 6).

Drug	Percent who had tried the drug
Hashish	48.5
Ecstasy	16.8
Heroin	13.9
Speed	19.8
Other	24.8

Table 6. Drug use in the previous year in pupils who had contacted Samaritans

Smoking, Drinking and Drug Taking

More than a third (36.3 per cent) of the adolescents who had contacted Samaritans currently smoked, compared with less than a quarter of the pupils who had not done so. The biggest difference between adolescents who had and had not contacted Samaritans was in the percentage that had never smoked and the percentage that smoked more than 50 cigarettes per week (Figure 16).

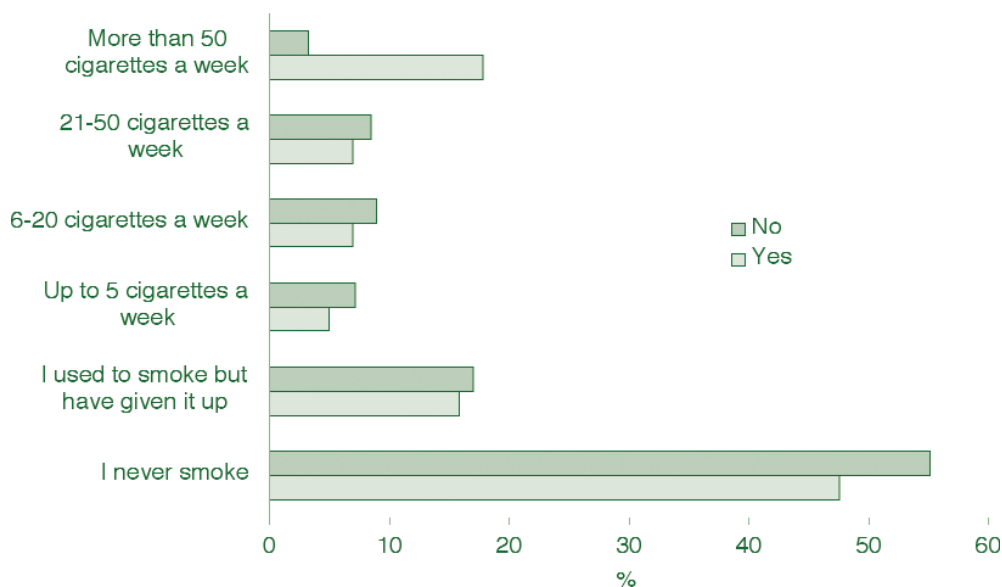


Figure 16. Number of cigarettes smoked by adolescents who had and had not contacted Samaritans.

Adolescents were asked how many alcoholic drinks they had in a typical week. Adolescents who had contacted Samaritans were more likely to have had more than two drinks than adolescents who had not contacted Samaritans and were much more likely to have more than 20 alcoholic drinks (Figure 17).

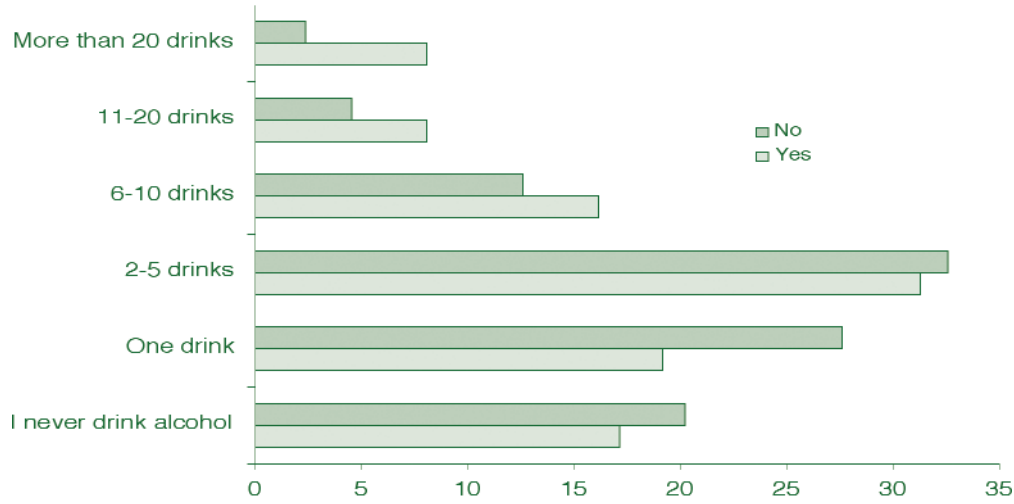


Figure 17. Number of alcoholic drinks in a typical week

Adolescents were also asked how many times they had been drunk in the past year. The most notable difference between adolescents who had and had not contacted Samaritans was that many more of those who had contacted them had been drunk and reported being drunk more than 10 times (Figure 18).

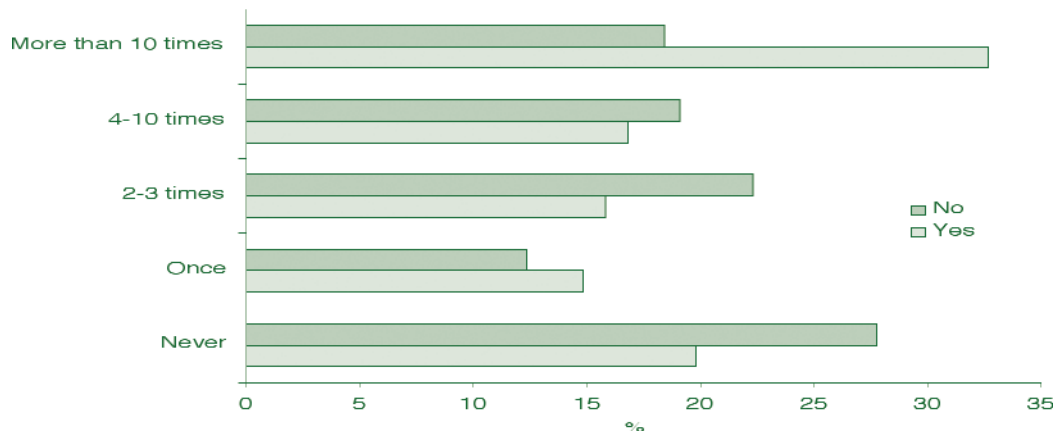


Figure 18. Number of times drunk in the past year.

Pupils were asked to indicate which types of drugs they had taken in the previous year. All types of drugs were more likely to have been taken by those who had contacted Samaritans than adolescents who had not contacted the organisation (Figure 19).

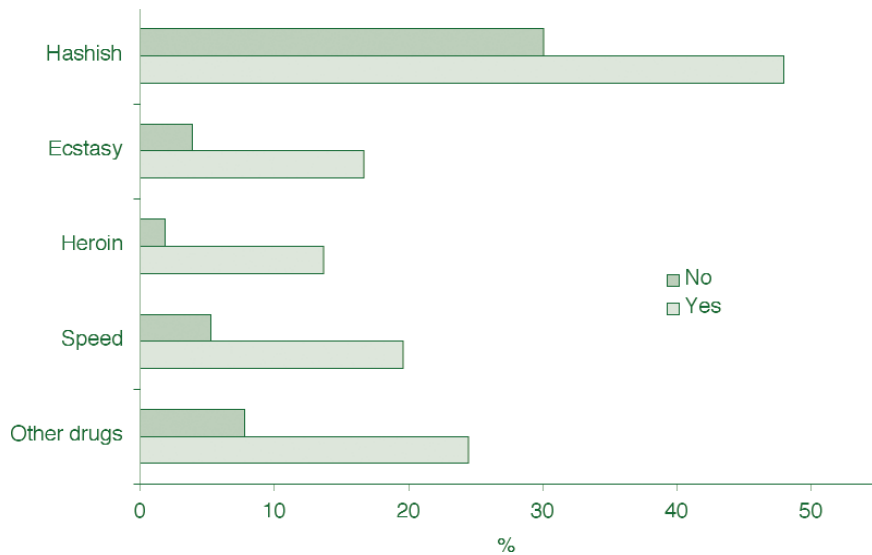


Figure 19. Types of drugs taken in the past year.

Pupils who considered contacting Samaritans

463 pupils had thought about contacting Samaritans but had not done so. Many more females (70 percent) than males (30 percent) had considered contacting Samaritans. They were asked about what had made them decide not to contact Samaritans (Figure 20). Most adolescents did not do so because they were too embarrassed, didn't have the confidence, thought their problems were too trivial, or worried about confidentiality. Males were more likely than females to think that Samaritans wouldn't understand their problems.

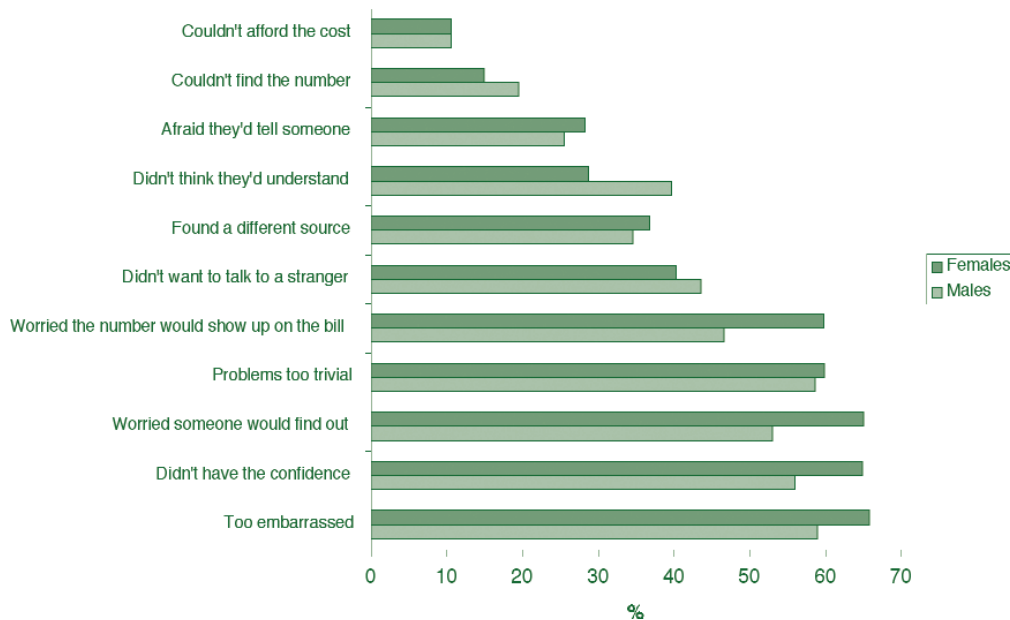


Figure 20. Reasons why pupils did not contact Samaritans

Adolescents who had considered contacting Samaritans were generally experiencing similar numbers and types of problems to adolescents who had contacted Samaritans. There were however some significant differences between these two groups (Figure 21). Adolescents who had only considered contacting Samaritans were more likely to be having problems with schoolwork than adolescents who had contacted Samaritans, but were less likely to have been in trouble with the police, experienced forced sexual activity and be having concerns about their sexual orientation.

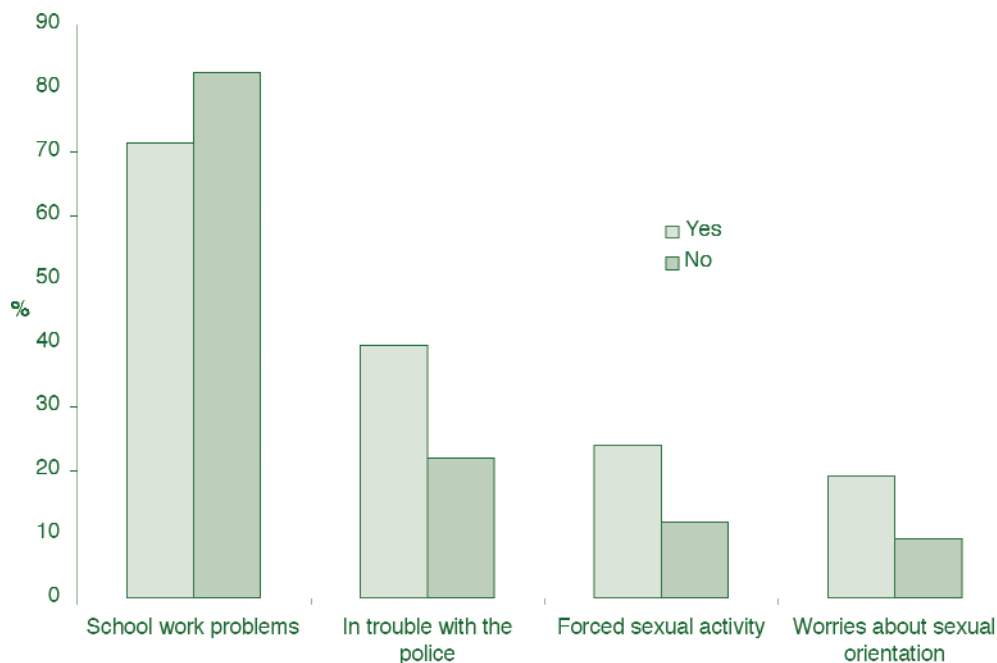


Figure 21. Differences in life events and problems between adolescents who had contacted Samaritans and those that had only considered contacting them

Pupils who had not considered contacting Samaritans

Of the pupils who had heard of Samaritans, 87.9 per cent had never considered contacting them. These pupils were asked to indicate why this was by choosing from a list of options (Figure 22). Most did not consider contacting Samaritans because they had received help from other sources or they said they did not have problems that were severe enough to warrant seeking such help.

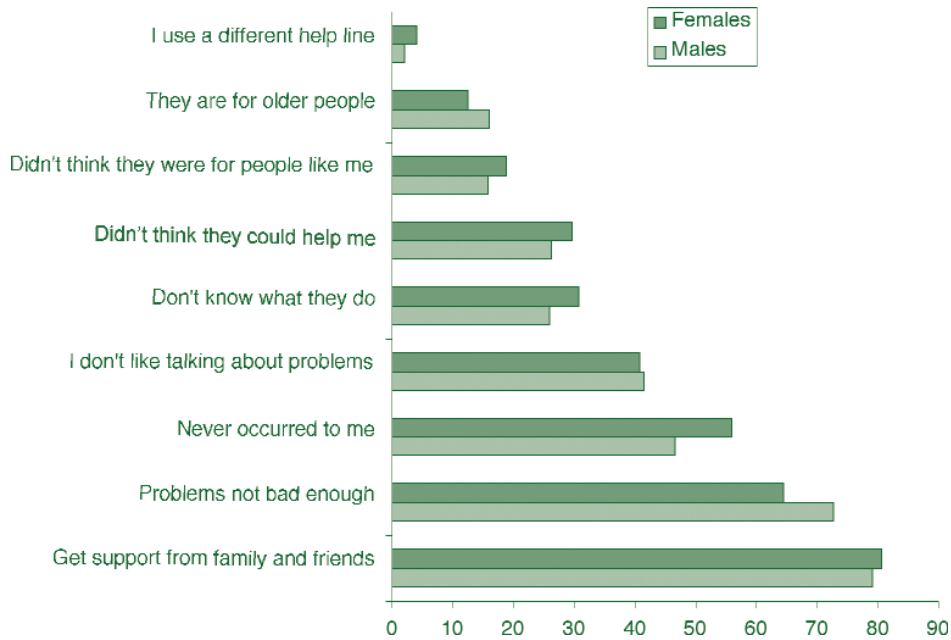


Figure 22. Reasons why pupils had not thought about contacting Samaritans

Pupils perceptions of Samaritans

All pupils were asked what they thought Samaritans provide. Although Samaritans volunteers do not give advice, the vast majority of adolescents thought they did (Figure 23). Interestingly, when the pupils were asked what they thought the best ways were for Samaritans to help adolescents, 'give advice' was a common response (Table 7).

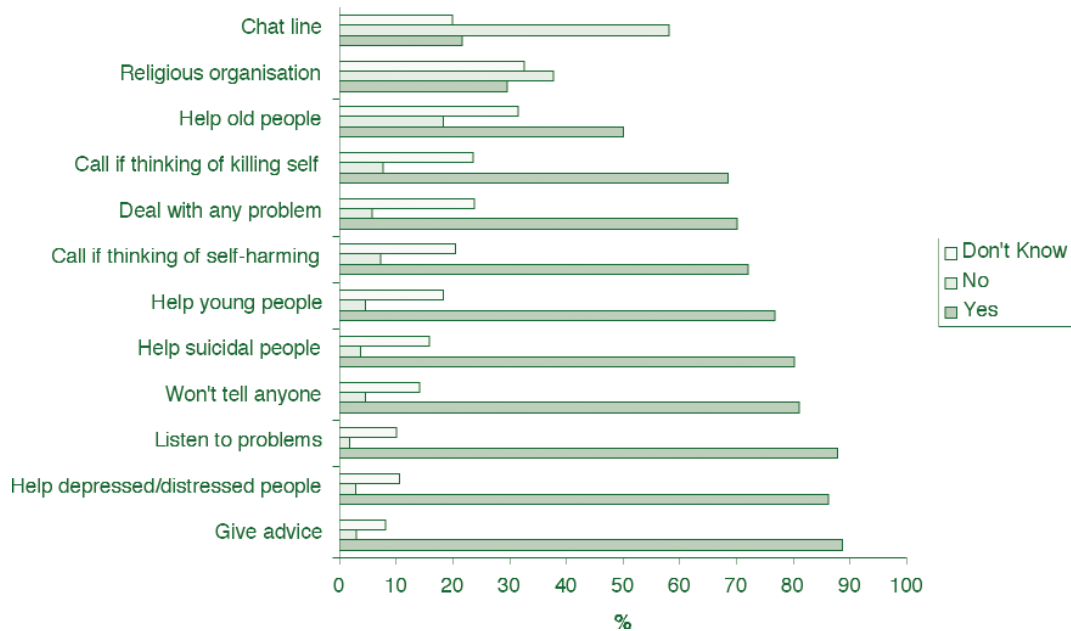


Figure 23. What pupils thought Samaritans do provide?

How can Samaritans best help young people with problems?

The pupils were asked how Samaritans could best help young people with problems. Responses to this question fell into four main categories:

(1) Give advice: Samaritans should not simply listen, but should also offer advice and solutions to problems experienced by callers.

Talk to them, be friendly with them and give advice
To sit and listen to them, try to give advice that they could use, don't judge them
To listen to their problems and give them advice about how to deal with them. To help them cope with bad things in life
By listening to them and looking at the problems from a young persons view but with adult experience so they can give good advice

Table 7. Sample of quotes from pupils who thought that Samaritans should give advice

(2) Advertise: Samaritans could improve their advertising so that younger people would be more aware of the services available to them.

Advertise their organisation more so people know its there if they ever need to talk to anyone
Make themselves more known. Make people feel confident enough to talk to them and tell them that the conversation is confidential and personal
Publicity should be a major issue (people need to know about Samaritans)

Table 8. Sample of quotes from pupils who thought that Samaritans advertise more

(3) Empathy / Experience: Samaritans should have the ability to empathise with young people. One way forward that was suggested was to recruit younger people as volunteers who they felt would understand them.

By having people that have been through it themselves and have young people on the phone so that the caller can relate to the Samaritan
We would need to talk to youngish people - 17-24 that could relate to our problems and understand us and we may be able to trust them completely
They should have young members so that youngsters like us can talk to them as young members have the right attitude to help these people

Table 9. Sample of quotes from pupils who thought that Samaritans should have the ability to empathise with young people

(4) School visits: Samaritans should visit schools on a regular basis so that pupils who wanted to could talk to them.

People come to schools and ask children out of class (interview them) if they have any problems they wish to discuss
They should come to schools/youth clubs
Come into schools on a regular basis and talk to every child
Coming to the school and talking to students who have problems
Visit a lot more schools so young people know what it was all about

Table 10. Sample of quotes from pupils who thought that Samaritans should visit schools

Another prominent theme concerned the stigma that adolescents perceive surrounding the action of 'asking for help' and also their feeling that there was a need to ensure that young people recognise that Samaritans are available to talk about all problems no matter how big or small. In fact this is in line with the suggestions made by the young people themselves:

I don't know but people might get embarrassed going to them and people might take the mickey out of them so that is why people don't always go to them

Most young people don't have enough confidence to call helplines

Make it more appealing to everyone so people don't feel scared of asking for help

Update themselves - many young people I know think it to be shameful if they contacted these organisations. If they were modernised it may not be as bad.

They need to be appealing to young people who have problems so they feel they can turn to them. If they looked and sounded appealing the people might feel more at ease to contact them.

Make sure that young people know what it is about, but some people think that they are stupid to ask for help if they need it so they need to ensure people that if something is worrying you, you can talk to them especially if its free.

In their adverts they just seem to be helping those with huge problems so they could show that they help those with little problems as people don't think that their problems are significant.

Table 11. Sample of quotes from pupils who made suggestions for improving the service offered by Samaritans

Summary and implications

Summary and implications

In this study we set out to establish the prevalence of deliberate self-harm and suicidal thoughts in a large representative sample of school pupils in England. The findings demonstrate that both deliberate self-harm and suicidal thoughts are common, particularly in girls. Thus 6.9 per cent reported deliberate self-harm episodes (meeting study criteria) in the previous year (11.1 per cent females, 3.2 per cent males) and 15.0 per cent reported suicidal thoughts (22.4 per cent females and 8.5 per cent males). In addition, a substantial proportion of other pupils reported episodes of deliberate self-harm earlier in their lives.

The prevalence figures we have reported for deliberate self-harm were based on applying strict criteria to descriptions that were provided by the pupils. Such an approach has not, to our knowledge, been used in previous studies. They have simply relied on whether or not adolescents reported self-harm. The figures for deliberate self-harm found using our approach would have slightly underestimated the true prevalence, because some adolescents did not supply a description of their acts. However, they will be more accurate than the figures reported in most other studies.

The findings show that deliberate self-harm and suicidal thoughts are important problems in adolescence and require serious attention. They also have implications for prevention. Since the vast majority of pupils who self-harm in the community do not present to hospital, especially those who engage in self-cutting, prevention has to be focused primarily at the community level, rather than just relying on the input of clinical services, although these are clearly important for adolescents who reach them as a result of their deliberate self-harm acts or thoughts of suicide.

In this study we have identified factors associated with deliberate self-harm and suicidal thoughts in adolescents. Factors associated with both suicidal thoughts and actual acts of self-harm were exposure to friends who had harmed themselves and having low self-esteem. Exposure to deliberate self-harm in the family was also associated with self-harm by pupils. Drug use was related to self-harm, but drunkenness only to suicidal thoughts. Concerns about sexual orientation were related to thoughts of self-harm by females, but physical abuse was associated with suicidal thoughts in the males. Anxiety was linked to suicidal thoughts in both genders. Both depression and anxiety were associated with self-harm in the females. Impulsivity was also related to self-harm in the females.

We have also identified differences in coping strategies between these adolescents and others who do not entertain thoughts of suicide or carry out acts of self-harm. When faced with difficulties, pupils who self-harmed said they were less likely than other adolescents to use positive coping strategies such as talking to someone or trying to sort out the situation, and more likely to use negative strategies such as harming themselves, staying in their room, getting angry and drinking alcohol. The pattern in the pupils who had had suicidal thoughts tended to be between those with self-harm and the remainder of the pupils.

The findings suggest the need for school-based mental health preventive initiatives. An important aspect of prevention of mental health problems in adolescents is the extent to which adolescents feel able to seek help from friends, teachers and parents and also from professional and voluntary agencies. This study has demonstrated that young people see their peers as an important source of support. In the light from the results of the study, there is a major need for development and

evaluation of an educational programme that would address these issues. Other potential approaches include routine screening of adolescents to identify those at risk and helping teachers recognise such individuals. Research from the USA suggests the former may be effective but management of those identified as at risk will involve considerable resources and risk of discrimination. Promotion of help-lines, use of self-referral agencies, school-counselling services, including by email, are other potential actions. Evaluation of such initiatives should be an educational priority. The strong associations of self-harm with similar behaviour in peers indicates that how the occurrence of suicidal phenomena in schools and other institutional settings is managed may be vital in determining the extent of its future occurrence (Hazell 1991).

We have also investigated whether adolescents who faced problems have contacted or would contact Samaritans, and, if not, what it is that impedes them from using this widely available source of help. While a relatively large proportion of the total sample had experienced an episode of deliberate self-harm or had had suicidal thoughts, only 1.8 per cent of the total sample had actually contacted Samaritans. One of the most common explanations offered by adolescents for this was that they were too embarrassed to do so. Another was that they considered their problems to be too trivial. It seems that a concerted effort is required to dilute the stigma that adolescents perceive surrounding 'asking for help' and also to ensure that the young people recognise that agencies like Samaritans are available to talk to anyone with problems no matter how big or small.

This study and the associated systematic review of the international literature in this field have highlighted issues for future research. One is the need in surveys of self-harm to have young people actually describe their acts of self-poisoning or self-injury. This has not been done in previous investigations. Having a description of self-harm enables researchers to determine if it is actually in keeping with their criteria. It also provides the opportunity to compare different types of self-harm with regard to subsequent help seeking, motives, and so on. This research has also highlighted the need for longitudinal studies that can track adolescents over time. This will help in the clarification of factors which increase risk of suicidal phenomena and in investigating help-seeking patterns. Finally, the results have emphasised the need for development and evaluation of preventive initiatives in schools and other settings. Such developments require careful evaluation.

What next?

What next?

The survey of a large and representative sample of school pupils has shown that deliberate self-harm and thoughts of suicide are common in adolescents, especially females. Awareness of this issue raises the urgent question of what should be done to help adolescents so that they do not get to the stage of thinking that life is not worth living and also to help those who have got as far as harming themselves.

Reaching out in schools

The results of this research point to the need for the development of preventive initiatives in school settings. One approach should be the development of general educational programmes to promote psychological health. These could, for example, focus on recognition of emotional problems in pupils themselves and in their peers. Pupils can be helped to explore methods of tackling such difficulties, including through lifestyle changes and seeking help. It will also be important to encourage adolescents to support peers who are in difficulties.

Teachers can be helped to recognise pupils who are getting into difficulties that might lead to deliberate self-harm.

A more controversial approach is the use of screening procedures to detect those pupils who are at risk.

Schools need advice on what to do when self-harm is recognised, especially if a cluster of such acts seems to be developing. All of this places burdens on schools and teachers. They will require the support of other agencies, both from health and social services, and also from voluntary organisations such as Samaritans. These initiatives also have implications for training and development programmes for teachers.

The findings of the research have implications for other types of agency. The media, for example, can play an extremely important role in providing information about emotional issues, help-seeking, peer support and so on. At the same time, they should be aware of the risks of irresponsible portrayal or reports of suicidal behaviour.

Tailored help and support

It is essential to create a dialogue with young people where we find out what type of access to 'helping organisations' they want and how best to support their needs. This would involve further research work, via focus groups, looking at what sort of advice and solutions to callers' problems they would find helpful. Further exploration of what this meant by offering 'advice' and 'solutions' is required in order to inform new service developments.

Recognising that young people need to know more about what help is available and what strategies promote "well being", Samaritans is developing an emotional health promotion strategy. This will encourage young people to recognise the value of being able to express feelings, respect and acknowledge the feelings of others. Samaritans' Emotional Health Programme will be rolled out in late 2003. As part of this programme young people in schools will be presented with more effective coping and help-seeking strategies.

Working with partner agencies

Already, Samaritans is forming referral partnerships with organisations, such as Youth Net, that specifically offer advice to young people.

One of the aims of this research was to disseminate information about the prevalence of self-harm amongst other helping organisations in order to inform their work with young people at risk of self-harm. This is being done through publications in peer-reviewed journals (e.g. Hawton et al, 2002), presentation at meetings and conferences and a symposium to announce the findings of this research and help other agencies shape the way services are offered and publicised to this age group.

In addition, this research is directly relevant to current health service priorities and should therefore inform the research agenda, especially in relation to mental health promotion and suicide prevention in adolescents.

Relevance for today's society

Young people have told us that there is stigma in 'asking for help' and want agencies like Samaritans to be relevant and accessible for young people in today's society. In September 2002, the organisation relaunched itself to ensure that it is available for everyone, everywhere. It is committed to providing emotional health support in a consistent way across the organisation.

A new strategy for recruiting and training, experienced volunteers to offer confidential emotional support aims to diversify the volunteer base of Samaritans. Samaritans wants to ensure that every walk of life is represented within its volunteer workforce, ready to support people who need emotional support. Targeted campaigns aim to recruit younger volunteers and people from minority ethnic groups.

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