University of Southampton

Doctoral Programme in Educational Psychology

Title: What is the Role of Schools and Colleges in Supporting Adolescents who Self-Harm?

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Abstract

Self-harm is a widespread issue amongst adolescents, which is often kept hidden from adults. When a young person is identified as self-harming, education professionals often refer them to Child and Adolescent Mental Health Services for an assessment. This may be due to the prevailing perception of self-harm as a mental health problem that requires clinical treatment and management. However, as the majority of self-harm behaviour is kept hidden, this essay will argue that a reactive response is unlikely to be adequate in supporting adolescents who self-harm. Instead, it will be argued that self-harm may be better perceived as an emotional and behavioural difficulty that can be effectively supported by education professionals working in schools and colleges. Rather than perceiving self-harm as a mental health problem, and the responsibility of clinicians, self-harm needs to be understood as an adaptive strategy that enables adolescents to regulate their emotions and cope with the stress of everyday life. This essay will demonstrate that adolescents who self-harm have fewer functional coping strategies and engage in self-harm as a way to alleviate negative emotions. It will be argued that education professionals are better placed to support children's development through the implementation of whole school approaches designed to develop young people's emotional intelligence and problem solving skills. By providing young people with culturally acceptable coping strategies, we may be able to help reduce the occurrence of self-harm behaviour.

What is the Role of Schools and Colleges in Supporting Adolescents who Self-Harm?

Self-harm is often viewed as the responsibility of clinicians due to its association with psychological distress (Hawton, Rodham, Evans, & Weatherall, 2002; Madge et al., 2011; Moran et al., 2012) and increased risk of suicide (Hawton & James, 2005; Hawton, Zahl, & Weatherall, 2003; McMahon et al., 2014). While cases of self-harm in adolescents can be referred to Child and Adolescent Mental Health Services (CAMHS), research suggests that the majority of self-harm behaviour is never brought to the attention of clinicians (McMahon et al., 2014; NICE, 2004) and that only about 12 percent of adolescents seek medical help following an episode of self-harm (Hawton et al., 2002; Kidger, Heron, Lewis, Evans, & Gunnell, 2012). However, surveys from non-clinical populations indicate that self-harm is a relatively widespread issue and, although prevalence rates vary considerably, it has repeatedly been found that approximately 10 to 13 percent of adolescents report self-harm behaviour (Hawton et al., 2002; Madge et al., 2008); figures are often higher for girls than boys (Laye-Gindhu & Schonert-Reichl, 2005; Madge et al., 2008).

Research indicates that much of self-harm is kept hidden by young people (Meltzer, Harrington, Goodman, & Jenkins, 1999) and that many forms of self-harm behaviour in schools are not always visible (Simm, Roen, & Daiches, 2008, 2010). According to Best (2005, p.277), pupils who are identified as self-harming represent only the ‘tip of the iceberg’. Although an immediate referral may be required in some of these cases, a reactive response is unlikely to be adequate in supporting the majority of pupils who self-harm. Therefore, this raises questions about the extent to which self-harm should be viewed as the responsibility of clinicians or whether schools and colleges could have a more central role.

One possible reason for the aforementioned variation in prevalence rates is that, despite the vast quantity of published research, there appears to be little consensus on the definition of self-harm and what should be included. This has led to a multitude of different terms including deliberate self-harm (DSH), non-suicidal self-injury (NSSI), self-injury, self-injurious behaviour (SIB), self-destructive behaviour, self-cutting and attempted suicide (Best, 2006). Due to the variety of terminology used throughout research, this essay will adopt the term self-harm in order to maintain consistency, seeing it as an overarching term that is inclusive of all others. Due to the contentious nature of the definition, this will be discussed further in the first section of this essay. It is also important to note that this essay will focus primarily on self-harm in adolescence, with this defined by the World Health Organisation (WHO, 2015) as 'the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19'. While it is the view of this author that self-harm can occur in children of a younger age, adolescence is believed to be the typical age of onset of self-harm behaviour (Hawton, Hall, et al., 2003). However, due to ethical constraints in researching self-harm in young children, adolescence is an age when self-harm is known to be prevalent (Hawton & Harriss, 2008) but also well researched.

In order to explore the role of education professionals in supporting adolescents who self-harm, this essay will first consider the definition and perceptions of self-harm. It will then examine the evidence surrounding the adaptive function of self-harm for emotion regulation, a term used synonymously with affect regulation and defined by Klonsky (2007) as the alleviation of negative emotions or emotional arousal. It is important to note that the terms affect and emotion will be used interchangeably, as they are in research, with emotion defined as our subjective

experience of feelings (e.g. sadness) and their underlying states (e.g. physiological arousal) (Tsuchiya & Adolphs, 2007). This essay will argue that self-harm is important for emotion regulation, but that coping strategies play a central role. Finally, the implications of this for schools, colleges and Educational Psychologists (EPs) will be explored.

The Definition of Self-Harm

A fundamental problem in any discussion of self-harm is that there is currently no consensus on how to define it, with different researchers using varying terms and definitions. This issue is reflected in section three of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5; American Psychiatric Association, 2013), where self-harm was recognised as a widespread problem that exists independently of other diagnosable conditions, but also as something not yet fully understood and requiring further research. One definition that has been widely used in the UK is that provided by the National Institute for Clinical Excellence (NICE), which defines self-harm as 'self-poisoning or self-injury, irrespective of the apparent purpose of the act' (NICE, 2004, p.16). This definition is comparable to that used by the World Health Organisation (WHO) in the International Classification of Diseases and Related Health Problems (ICD-10; WHO, 2015), whereby self-harm is inclusive of self-inflicted poisoning, or injury, as well as attempted suicide.

However, in contrast to the aforementioned definitions, there is evidence to suggest that the intention behind the act may be important (Jacobson & Gould, 2007; Nock, 2008), with the majority of individuals who engage in self-harm behaviour reporting no intention to commit suicide (Kidger et al., 2015, 2012). For this reason, some researchers such as Jacobson and Gould (2007) and Nock (2008) prefer to

exclude attempted suicide from their definition. Although the definitions by WHO and NICE do not suggest that all individuals who self-harm will have suicidal intent, they do serve to 'label' everyone under an umbrella term. However, Stanford and Jones (2009) found that adolescents who self-harm could be subdivided into three distinct psychological subtypes, including pathological (e.g. high anxiety and depression), impulsive and psychologically 'normal'. This suggests that they should not be treated as a homogenous group and that different types of support may be required.

In attempting to define self-harm, it is also important to acknowledge the cultural context in which the definition exists, with Turp (2002) coining the acronym CASHA to stand for culturally accepted self-harm acts. She argued that many forms of self-harm are accepted within different cultures, including body piercing and chronic overwork. Injuries arising from reckless behaviour and inattention are often accepted and are not therefore recognised by professionals. Although a full discussion of CASHA is outside the scope of this essay, it is important to keep in mind that self-harm behaviour may exist on a continuum ranging from 'good enough' self-care (Winnicott, 1960, in Turp, 2002) to severe self-harm, with different individuals and cultures having different cut off points. However, as demonstrated by Laye-Gindhu and Schonert-Reichl (2005), adolescents do appear to recognise hidden forms of self-harm, including eating disorders, reckless behaviour and bone-breaking. This demonstrates that adolescents do not necessarily define self-harm behaviour in the same way as clinicians and researchers.

Perceptions of Self-Harm

While clinicians adopt a medical perspective and label psychological and emotional difficulties as mental health problems, education professionals are more likely to consider the perspective of emotional and behavioural difficulties (Maxwell et al., 2007). This suggests that the perception of self-harm may vary between professions, with this influencing how people respond and whether the behaviour is seen as requiring medical management, and treatment, or emotional and behavioural support. Although teachers might be expected to adopt the latter perspective, research indicates that this is not the case and that the medical model is dominant in education. Best (2005) conducted interviews with teachers, support workers and staff from other agencies, and found that typical responses to self-harm behaviour included 'feeling that the problem is beyond teachers' competence to deal with', with parents immediately informed and referrals made to outside agencies, such as CAMHS. This suggests that self-harm is viewed as a behaviour that requires an expert clinical response.

One explanation for such referrals is that teachers react to self-harm with shock, panic, sadness and distress (Simm et al., 2010); Heath, Toste and Beettam (2006) found that almost half of all teachers agreed with the statement 'I find the idea of cutting or burning the skin horrifying'. This may be due to the inaccurate perception that 'the seriousness of the problem can be measured by the severity of injury' (Fox & Hawton, 2004; Simm et al., 2008). In contrast, research conducted by Fortune, Sinclair and Hawton (2008) found that adolescent descriptions of self-harm differed considerably, perceiving it as 'spur of the moment', 'not that serious or important' and 'my choice'. Adolescents often reported feeling that they should be

able to cope on their own and that other people would not understand or care about their problems. Despite these views, it could be argued that adolescents who engage in self-harm behaviour have problems that they are unable to cope with alone (Fortune et al., 2008). While this research could be criticised for its reliance on retrospective reporting of self-harm, it is important to note that the use of open-ended questions was a relative strength and may have provided a more representative view of adolescents.

One stereotypical view of self-harm is that it is a form of attention-seeking behaviour (Walsh and Rosen, 1988). Research suggests that a small number of teachers share this belief about self-harm, stating that it is a way for young people to manipulate others and gain attention (Simm et al., 2010). This belief was reflected in the reports of adolescents who, in addition to worrying about hurting the people they cared about, also raised concerns about being labelled as attention seekers (Fortune, Sinclair, & Hawton, 2008). As this view was found to be prevalent in at least one-fifth of teachers (Heath et al., 2006), this suggests that adolescents' concerns may be valid. However, as self-harm behaviour often remains hidden, it cannot serve the purpose of gaining attention from other individuals. Nonetheless, if adolescents are worried about being perceived as an attention seeker, this may act as a barrier to help-seeking behaviour (Fortune, Sinclair, & Hawton, 2008). While the perception of self-harm as attention-seeking behaviour is inaccurate, how staff attribute the behaviour will influence the way it is managed in schools (Simm et al., 2010). Based on attribution theory (Weiner, 1985) people who perceive the behaviour of others to be within the individual's control are more likely to withhold help. However, as this essay will now discuss, self-harm may serve an adaptive function, with adolescents needing more support from their teachers, not less.

The Adaptive Function of Self-Harm for Emotion Regulation

It has been shown that teachers react negatively to self-harm behaviour, with some feeling that it is beyond their competence while others dismiss it as attention-seeking. However, it can be argued that this perception of self-harm stems from a lack of understanding of the purpose of self-harm behaviour. Gross, Richards and John (2006) suggest that, in everyday life, people try to down-regulate negative emotions like anger and sadness and up-regulate positive emotions. This suggests that one possible function of self-harm is for emotion regulation, with self-harm behaviour providing adolescents with a way to achieve this down-regulation of negative emotions. Research supports this view, with Laye-Gindhu & Schonert-Reichl (2005), finding that adolescents reported negative affective states prior to episodes of self-harm, but that these reduced both during and after self-harm; reduced negative affect was often accompanied by an increased sense of relief. This is further supported by research on young adults (Klonsky, 2009), where self-harm behaviour was more strongly associated with decreased negative affect than increased positive.

Gross (2015) developed a four step process model of emotion regulation and suggested that we can influence the emotion regulation process at any of the following sequential steps including, situation, attention, appraisal and response. Only the latter occurs in response to the emotion, indicating that self-harm operates at the final step and is used to help change the emotions experienced. Self-harm may be viewed as a last resort method of emotion regulation that occurs only if the individual has been unable to makes changes at earlier steps. Klonsky (2007) carried out a review of the functions of self-harm and found evidence supporting the role of emotion regulation. However, his paper highlights one problem with self-harm research in that it has

typically involved clinical populations, such as inpatients. Of the research reviewed, only two studies involved non-clinical samples and, of these, only the aforementioned study by Laye-Gindhu & Schonert-Reichl (2005) involved an adolescent population. As it is known that the majority of cases of self-harm are unreported, clinical samples represent only a small and potentially biased subset of the adolescent population.

Newer research from wider school-based populations has also begun to show that self-harm is important for emotion regulation. While Mikolajczak, Petrides and Hurry (2009) found that 80 percent of self-harming adolescents used self-harm as a way to regulate their emotions, further research has shown that approximately two-thirds of adolescents who self-harmed, were seeking to gain alleviation or relief from negative emotions (Kidger et al., 2012; Scoliers et al., 2009). However, Scoliers et al. (2009) also found that one-third of adolescents wanted to show how desperate they were feeling, suggesting that self-harm may provide an effective way for adolescents to express their emotions. It is important to note, though, that such survey based research is heavily reliant on retrospective questionnaires with predetermined statements; this may have a suggestive effect or result in inaccurate recollection (Scoliers et al., 2009).

Research also suggests that self-harm may operate through a process of negative reinforcement. Chapman, Gratz and Brown (2006) argued that self-harm provides temporary relief from unwanted negative emotions which, over time, becomes a more automatic response. They argue that an individual who is unable to use functional coping to deal with their negative emotions is more likely to turn to self-harm as a form of emotion regulation strategy. The reduction in negative affect, which results from this behaviour, increases the likelihood of repeated self-harm.

Klonsky (2009) found evidence to support the negative reinforcement of self-harm behaviour, with young adults who experienced the largest reductions in negative affect reporting the greatest amount of self-harm. Kidger et al. (2012) support this view, finding that as the frequency of self-harm increased so did the likelihood that the adolescent would feel better.

Self-Harm and Coping Strategies

Coping strategies have been defined as 'behavioural and cognitive efforts that people employ in order to deal with stressful situations' (Evans, Hawton and Rodham, 2005, p.574). This has led some researchers to suggest that self-harm is a type of coping strategy that helps with emotion regulation (Laye-Gindhu & Schonert-Reichl, 2005). Two types of coping strategy that have been proposed include problem-focused and emotion-focused (Lazarus & Folkman, 1984). While the former actively manages or alters the problem causing distress, such as talking to someone, the latter aims to regulate emotional responses to the problem and includes disengagement and avoidance (Folkman and Lazarus, 1980, in Lazarus & Folkman, 1984). This fits with the process model of emotion regulation (Gross, 2002, 2015) in that problem-focused and emotion-focused coping strategies may include attempts to: modify the situation that is having an emotional impact, alter what is being attended to, or help think about problems in a different way (Gross, 2015). For some individuals who are unable to regulate their emotions effectively at these earlier steps, self-harm may be a response.

Research suggests that when confronted with difficulties, adolescents who self-harm employ different coping strategies from their peers, with McMahon et al. (2013) finding that emotion-focused coping was higher in self-harming adolescents than problem-focused. Evans et al. (2005) found that adolescents who self-harmed

were more likely to employ avoidance strategies, like staying in their room, and less likely to focus on the problem by talking to someone. This latter finding was supported by Guerreiro, Figueira, Cruz, and Sampaio (2015) and may reflect the fact that adolescents who self-harmed had fewer categories of people to whom they could go to about their problem than other adolescents (Evans et al., 2005). Given that significantly more self-harming adolescents report having serious personal, emotional, behavioural or mental health problems (Evans et al., 2005), this lack of people to talk to could leave them unable to employ problem-focused coping strategies as suggested by Chapman, Gratz and Brown (2006).

The Protective Role of Emotional Intelligence

Although adolescents who self-harm are more reliant on emotion-focused coping than problem-focused coping, not all adolescents who experience negative emotions choose self-harm as a way to regulate them. Research suggests that adolescents who engage in self-harm behaviour have lower emotional intelligence (EI) than their peers (Kulikowska & Pokorski, 2008; Mikolajczak et al., 2009), with emotional intelligence (EI) defined as our ability to recognise and express our own emotional states in order to solve problems and regulate our behaviour (Salovey & Mayer, 1990). Mikolajczak et al. (2009) found a significant negative correlation between EI and self-harm, suggesting that high EI may help protect against self-harm. However, as research was only collected at a single point in time, causality cannot be established. They also found that self-harm was related to maladaptive coping strategies, including emotional coping and avoidance, with these partly explaining the relationship between EI and self-harm. While some research has favoured the role of avoidance strategies (Evans et al., 2005; Guerreiro et al., 2015), others have found

that emotional coping plays a greater role (Kulikowska & Pokorski, 2008; Mikolajczak et al., 2009). This has led to the suggestion that 'self-harm may be a desperate attempt to down-regulate the negative feelings that are exacerbated by ineffective emotional coping strategies' (Mikolajczak et al., 2009, p.190).

Further support for the role of coping strategies, in the relationship between EI and self-harm, was provided by Mahajan, Mahajan and Singh (2014). They looked at self-harming adolescents and found that in addition to poor EI, maladaptive coping styles were common, including distancing and escape avoidance. For adolescents with high EI, there was a significant increase in adaptive coping strategies and corresponding decrease in maladaptive coping strategies. However, it is important to note that this study was a relatively small-scale piece of research carried out in India on a clinical sample. While this does not invalidate the results, it does raise questions about the generalisability of the findings.

Research suggests that EI intelligence and coping strategies are inextricably interlinked. If adolescents are to be able to manage the stress they experience in everyday life, it is important they have functional coping strategies. However, as research has shown, adolescents who engage in self-harm behaviour may have fewer acceptable problem solving strategies available (McMahon et al., 2013). This suggests that it is important to teach children and adolescents more positive and constructive coping strategies and help them develop problem solving skills (Laye-Gindhu & Schonert-Reichl, 2005).

Implications for Schools and EPs

Self-harm is primarily perceived as a mental health issue that requires treatment from clinicians and, when cases of self-harm occur, they are typically referred to 'experts' such as CAMHS. However, as this essay has shown, self-harm may be better perceived as an emotional difficulty which serves an adaptive function for the alleviation of negative emotions. Adolescents who lack functional coping strategies, such as problem solving skills, are more likely to engage in self-harm behaviour to help regulate their emotions. This suggests that by proactively teaching adolescents the skills needed to solve problems, and seek help from adults, we could potentially reduce the number of adolescents who engage in self-harm. Also, by viewing self-harm as an emotional difficulty, schools and colleges may be more likely to perceive self-harm as within their area of expertise, rather than something necessitating a referral.

One current barrier to help-seeking in adolescents is the way self-harm is perceived by those working in education. As teachers typically respond to cases of self-harm with feelings of anxiety and panic, this indicates that they are unable to cope with the knowledge that a young person is self-harming. Referrals to 'experts' may communicate a message of rejection to the adolescent, leading to an escalation in self-harm behaviour. Based on this information, it could be argued that one central role for EPs is in helping to raise awareness of self-harm in schools. However, as suggested by Best (2006), it is also vital that we train and equip teachers with the skills needed to deal with self-harm, as simply raising awareness could make the situation worse. If teachers are able to recognise cases of self-harm but do not have the skills to help, this may result in a young person being placed under continual

supervision or made to stop self-harming. This could be counterproductive as it may increase negative emotions in the young person while leaving them without the strategies to cope (Best, 2006); self-harm behaviour is more likely to be kept hidden. Through knowledge of self-harm as an adaptive coping strategy, teachers may be better able to respond with empathy and understanding.

However, adolescents rarely view teachers as a source of help for their problems, with the majority of adolescents reporting that they would talk to a friend about their problems rather than a teacher (Evans et al., 2005). This finding poses a problem for schools trying to provide support to young people experiencing difficulties, as it suggests that adolescents are unlikely to turn to their teachers for help. It also indicates that raising staff awareness is inadequate and that adolescents themselves need education and advice on when to seek help for their friends. While Evans et al. (2005) suggest that this might be a burden for adolescents, it could be argued that the failure to educate is simply ignoring the burden they already experience from helping their peers without adult support.

Research has also suggested that EI may serve a protective role for self-harm in that individuals with high EI are less likely to engage in self-harm behaviour (Kulikowska & Pokorski, 2008; Mikolajczak et al., 2009). However, as functional coping strategies may partly explain this relationship, this indicates that we need to promote programmes which support the development of EI and problem solving skills. This may help adolescents to develop the skills needed to articulate their emotions, and reduce the need to express them thorough self-harm.

It could be argued that EPs should be working at a school level in order to implement preventative strategies and interventions that may help reduce the

frequency of self-harm behaviour. One example is that of Promoting Alternative Thinking Strategies (PATHS), a whole school approach designed to increase children's emotional understanding and social problem solving skills. Staff may also be trained to implement cognitive behavioural interventions, such as the FRIENDS programme, which is designed to support young people to develop emotional skills and coping strategies. If a preventative approach is adopted, EPs could support primary schools to implement programmes such as Zippy's Friends, designed specifically for teaching younger children the skills needed to recognise and express their emotions, as well as coping with everyday problems.

Conclusion

Self-harm is typically perceived as a mental health problem and the responsibility of clinicians. However, it is the view of the author that self-harm may be better perceived as an emotional difficulty that requires the support of caring adults, including school and college staff. In order to achieve this shift in perspectives, it is important to understand that self-harm is not an attention-seeking behaviour but serves an adaptive function which enables young people to cope with the stress they experience in everyday life. For some adolescents, self-harm is a chosen strategy that helps to alleviate negative emotions, and may not be perceived as being a serious problem. By understanding the role of self-harm in emotion regulation, we may be better able to implement preventative strategies to help children and adolescents develop the skills needed to cope with their problems. If we can provide interventions to support and improve adolescents' emotional intelligence and coping strategies, then we may be able to help reduce the occurrence of self-harm behaviour. However, in

order to achieve this, EPs need to support schools and colleges to take a more central role.

References

American Psychiatric Association (APA) (2013). *Section III*. Retrieved from http://www.psychiatry.org/File Library/Practice/DSM/DSM-5/DSM-5-Section-III.pdf

Best, R. (2005). An Educational Response to Deliberate Self-Harm: Training, Support and School-Agency Links. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community*, *19*(3), 275–287. doi:10.1080/02650530500291070

Best, R. (2006). Deliberate Self-Harm in Adolescence: a challenge for schools. *British Journal of Guidance and Counselling*, *34*(2), 161–175. doi:10.1080/03069880600583196

Chapman, A. L., Gratz, K. L., & Brown, M. Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour Research and Therapy*, *44*(3), 371–394. doi:10.1016/j.brat.2005.03.005

Evans, E., Hawton, K., & Rodham, K. (2005). In what ways are adolescents who engage in self-harm or experience thoughts of self-harm different in terms of help-seeking, communication and coping strategies? *Journal of Adolescence*, *28*(4), 573–587. doi:10.1016/j.adolescence.2004.11.001

Fortune, S., Sinclair, J., & Hawton, K. (2008). Help-seeking before and after episodes of self-harm: a descriptive study in school pupils in England. *BMC Public Health*, *8*, 369. doi:10.1186/1471-2458-8-369

Fox, C., & Hawton, K. (2004). *Deliberate Self-Harm in Adolescence*. London: Jessica Kingsley Publishers.

Gross, J. J. (2002). Emotion regulation: affective, cognitive, and social consequences. *Psychophysiology*, *39*(3), 281–291. doi:10.1017.S0048577201393198

Gross, J. J. (2015). Emotion Regulation : Current Status and Future Prospects. *Psychological Inquiry*, *26*, 1–26. doi:10.1080/1047840X.2014.940781

Gross, J. J., Richards, J. M., & John, O. P. (2006). Emotion Regulation in Everyday Life. In D. K. Snyder, J. A. Simpson, & J. A. Hughes (Eds.), *Emotion Regulation in Couples and Families: pathways to dysfunction and health* (pp. 13–35). Washington DC: American Psychological Association. doi:10.1177/1469540507081630

Guerreiro, D. F., Figueira, M. L., Cruz, D., & Sampaio, D. (2015). Coping Strategies in Adolescents Who Self-Harm. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *36*(1), 31–37. doi:10.1027/0227-5910/a000289

Hawton, K., Hall, S., Simkin, S., Bale, E., Bond, A., Codd, S., & Stewart, A. (2003). Deliberate self-harm in adolescents: A study of characteristics and trends in Oxforder, 1990-2000. *The Journal of Child Psychology and Psychiatry*, *44*, 1191–1198.

Hawton, K., & Harriss, L. (2008). The changing gender ratio in occurrence of deliberate self-harm across the lifecycle. *Crisis*, *29*(1), 4–10. doi:10.1027/0227-5910.29.1.4

Hawton, K., & James, A. (2005). Suicide and deliberate self harm in young people. *BMJ (Clinical Research Ed.)*, *330*(7496), 891–894. doi:10.1136/bmj.330.7496.891

Hawton, K., Rodham, K., Evans, E., & Weatherall, R. (2002). Deliberate self harm in adolescents: self report survey in schools in England. *BMJ (Clinical Research Ed.)*, *325*(7374), 1207–1211. doi:10.1136/bmj.325.7374.1207

Hawton, K., Zahl, D., & Weatherall, R. (2003). Suicide following deliberate self-harm : long-term follow-up of patients who presented to a general hospital Suicide following deliberate self-harm : long-term follow-up of patients who presented to a general hospital. *British Journal of Psychiatry*, *182*, 537–542. doi:10.1192/02-540

Heath, N. L., Toste, J. R., & Beettam, E. L. (2006). "I Am Not Well-Equipped": High School Teachers' Perceptions of Self-Injury. *Canadian Journal of School Psychology*, *21*(1-2), 73–92. doi:10.1177/0829573506298471

Jacobson, C. M., & Gould, M. (2007). The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: a critical review of the literature. *Archives of Suicide Research : Official Journal of the International Academy for Suicide Research*, *11*(2), 129–147. doi:10.1080/13811110701247602

Kidger, J., Heron, J., Leon, D. a, Tilling, K., Lewis, G., & Gunnell, D. (2015). Self-reported school experience as a predictor of self-harm during adolescence: A prospective cohort study in the South West of England (ALSPAC). *Journal of Affective Disorders*, *173*, 163–169. doi:10.1016/j.jad.2014.11.003

Kidger, J., Heron, J., Lewis, G., Evans, J., & Gunnell, D. (2012). Adolescent self-harm and suicidal thoughts in the ALSPAC cohort: a self-report survey in England. *BMC Psychiatry*, *12*(1), 69. doi:10.1186/1471-244X-12-69

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*, *27*(2), 226–239. doi:10.1016/j.cpr.2006.08.002

Klonsky, E. D. (2009). The functions of self-injury in young adults who cut themselves: Clarifying the evidence for affect-regulation. *Psychiatry Research*, *166*(2-3), 260–268. doi:10.1016/j.psychres.2008.02.008

Kulikowska, A., & Pokorski, M. (2008). Self-injuries in adolescents: social competence, emotional intelligence, and stigmatization. *Journal of Physiology and Pharmacology*, *59*(Supplement 6), 383–392.

Laye-Gindhu, A., & Schonert-Reichl, K. a. (2005). Nonsuicidal self-harm among community adolescents: Understanding the "whats" and "whys" of self-harm. *Journal of Youth and Adolescence*, *34*(5), 447–457. doi:10.1007/s10964-005-7262-z

Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal and Coping*. New York: Springer Publishing Company.

Madge, N., Hawton, K., McMahon, E. M., Corcoran, P., De Leo, D., De Wilde, E. J., … Arensman, E. (2011). Psychological characteristics, stressful life events and deliberate self-harm: Findings from the child & adolescent self-harm in Europe

(CASE) study. *European Child and Adolescent Psychiatry*, *20*(10), 499–508. doi:10.1007/s00787-011-0210-4

Madge, N., Hewitt, A., Hawton, K., Wilde, E. J. De, Corcoran, P., Fekete, S., … Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: Comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *49*(6), 667–677. doi:10.1111/j.1469-7610.2008.01879.x

Mahajan, R., Mahajan, N. S., & Singh, D. P. (2014). Emotional intelligence and coping strategies in late adolescence presenting with deliberate self harm. *Delhi Psychiatry Journal*, *17*(2), 303–307.

Maxwell, C., Yankah, E., Warwick, I., Hill, V., Aggleton, D., & Mehmedbegov, P. (2007). *The emotional well-being and mental health of young Londoners: A focused review of the evidence*. Retrieved from http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/The-Emotional-Well-Being-and-Mental-Health-of-Young-Londoners.pdf

McMahon, E. M., Corcora, P., Mcauliffe, C., Keeley, H., Perry, I. J., & Arensman, E. (2013). Mediating effects of coping style on associations between mental health factors and self-harm among adolescents. *Crisis*, *34*(4), 242–250. doi:10.1027/0227-5910/a000188

McMahon, E. M., Keeley, H., Cannon, M., Arensman, E., Perry, I. J., Clarke, M., … Corcoran, P. (2014). The iceberg of suicide and self-harm in Irish adolescents: a population-based study. *Social Psychiatry and Psychiatric Epidemiology*, 1929–1935. doi:10.1007/s00127-014-0907-z

Meltzer, H., Harrington, R., Goodman, R., & Jenkins, R. (1999). *Children and adolescents who try to harm , hurt or kill themselves: A report of further analysis from the national survey of the mental health of children and adolescents in Great Britain in 1999*. *Office for National Statistics*.

Mikolajczak, M., Petrides, K. V, & Hurry, J. (2009). Adolescents choosing self-harm as an emotion regulation strategy: the protective role of trait emotional intelligence. *The British Journal of Clinical Psychology / the British Psychological Society*, *48*(Pt 2), 181–193. doi:10.1348/014466508X386027

Moran, P., Coffey, C., Romaniuk, H., Olsson, C., Borschmann, R., Carlin, J. B., & Patton, G. C. (2012). The natural history of self-harm from adolescence to young adulthood: A population-based cohort study. *The Lancet*, *379*(9812), 236–243. doi:10.1016/S0140-6736(11)61141-0

National Institute for Clinical Excellence (NICE) (2004). *The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*, 1–199, The British Psychological Society and The Royal College of Psychiatrists.

Nock, M. K. (2008). Actions speak louder than words: An elaborated theoretical model of the social functions of self-injury and other harmful behaviours. *Applied and Preventive Psychology*, *12*(4), 159–168. doi:10.1016/j.appsy.2008.05.002.Actions

Salovey, P., & Mayer, J. D. (1990). Emotional Intelligence. *Imagination, Cognition and Personality*, *9*, 185–211.

Scoliers, G., Portzky, G., Madge, N., Hewitt, A., Hawton, K., Wilde, E. J., … Heeringen, K. (2009). Reasons for adolescent deliberate self-harm: A cry of pain and/or a cry for help?: Findings from the child and adolescent self-harm in Europe (CASE) study. *Social Psychiatry and Psychiatric Epidemiology*, *44*(8), 601–607. doi:10.1007/s00127-008-0469-z

Simm, R., Roen, K., & Daiches, A. (2008). Educational professionals' experiences of self-harm in primary school children: "You don"t really believe, unless you see it'. *Oxford Review of Education*, *34*(2), 253–269. doi:10.1080/03054980701663967

Simm, R., Roen, K., & Daiches, A. (2010). Primary school children and self harm: the emotional impact upon education professionals, and their understandings of why children self harm and how this is managed. *Oxford Review of Education*, *36*(6), 677–692. doi:10.1080/03054985.2010.501139

Stanford, S., & Jones, M. P. (2009). Psychological subtyping finds pathological, impulsive, and "normal" groups among adolescents who self-harm. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *50*(7), 807–815. doi:10.1111/j.1469-7610.2009.02067.x

Tsuchiya, N., & Adolphs, R. (2007). Emotion and consciousness. *Trends in Cognitive Sciences*, *11*(4), 181–191. doi:10.1016/j.tics.2007.01.005

Turp, M. (2002). The many faces of self-harm. *Psychodynamic Practice*, *8*(2), 197–217. doi:10.1080/13533330210154655

Weiner, B. (1985). An Attributional Theory of Achievement Motivation and Emotion. *Psychological Review*, *92*(4), 548–573. Retrieved from http://discovery.ucl.ac.uk/125550/

World Health Organisation (WHO) (2015). *International Statistical Classification of Diseases and Related Health Problems: Online Version 2015* (10th ed.). Geneva: WHO. Retrieved from http://apps.who.int/classifications/icd10/browse/2015/en