healthcare

Special Issue Reprint

Health Risk Behaviours

Self-Injury and Suicide in Young People

Edited by
Jo Bell and Cathy Brennan

mdpi.com/journal/healthcare

MDPI

Health Risk Behaviours: Self-Injury and Suicide in Young People

Health Risk Behaviours: Self-Injury and Suicide in Young People

Editors

Jo Bell
Cathy Brennan

MDPI

Basel • Beijing • Wuhan • Barcelona • Belgrade • Novi Sad • Cluj • Manchester

Editors

Jo Bell
School of Psychology and Social Work
University of Hull
Hull
UK

Cathy Brennan
School of Medicine
University of Leeds
Leeds
UK

Editorial Office
MDPI AG
Grosspeteranlage 5
4052 Basel, Switzerland

This is a reprint of the healthcare, published open access by the journal *Healthcare* (ISSN 2227-9032), freely accessible at: https://www.mdpi.com/journal/healthcare/special_issues/0257V7F184.

For citation purposes, cite each article independently as indicated on the article page online and as indicated below:

Lastname, A.A.; Lastname, B.B. Article Title. *Journal Name* **Year**, *Volume Number*, Page Range.

ISBN 978-3-7258-8037-9 (Hbk)
ISBN 978-3-7258-8038-6 (PDF)
https://doi.org/10.3390/books978-3-7258-8038-6

Contents

About the Editors

Jo Bell

Jo Bell is a Reader in the School of Psychology and Social Work at the University of Hull in the UK. She is dedicated to research that seeks to understand adversity and human experience and that makes a difference to the lives of vulnerable people, particularly young people. Her research integrates three main strands: mental health, suicide prevention, and trauma and loss.

Cathy Brennan

Cathy Brennan is an Associate Professor in Psychological and Social Medicine at the School of Medicine, University of Leeds, UK. Her primary research interests are in Public Mental Health, with a particular focus on self-harm and suicidal behaviour and the development and evaluation of complex interventions. She is interested in the intersection between individual risk and the risk conferred as a consequence of environment or place (taking a broad conceptual view that includes wider cultural and environmental factors).

healthcare

MDPI

Editorial

Self-Harm and Suicide in Young People: Advancing Understanding and Intervention

Jo Bell [1,*] and Cathy Brennan [2]

[1] School of Psychology and Social Work, University of Hull, Hull HU6 7RX, UK
[2] School of Medicine, University of Leeds, Leeds LS2 9NL, UK; c.a.brennan@leeds.ac.uk
* Correspondence: j.bell@hull.ac.uk

Self-harm and suicide among young people represent one of the most pressing public health challenges facing contemporary societies. Over recent decades, rates of self-harm among adolescents and young adults have increased substantially in many countries, and suicide remains a leading cause of death among young people globally [1]. Self-harm is widely recognised as the strongest predictor of suicide, making early identification and intervention critical priorities for researchers, clinicians, and policymakers.

These behaviours are complex and cannot be understood through a single disciplinary lens [2]. Progress in the field increasingly depends on integrating psychological, social, cultural, and health-system perspectives. Research on self-harm and suicide among young people now spans qualitative studies of lived experience, theoretical models of suicidal behaviour, epidemiological investigations of risk and protective factors, and the development and evaluation of clinical interventions.

This Special Issue of *Healthcare*, *Health Risk Behaviours: Self-Injury and Suicide in Young People*, brings together contributions that reflect this multidimensional approach. The eight papers included in the collection examine the experiences of young people themselves, the psychological processes associated with self-harm and suicidal thinking, the influence of social and cultural environments, and emerging strategies for intervention and service delivery. Taken together, they offer new insights into the complexity of self-harm and suicide while also highlighting important gaps that remain in knowledge and practice.

Recent years have seen growing recognition that self-harm and suicide among young people arise from dynamic interactions between individual vulnerabilities, psychological processes, social environments, and structural inequalities. Traditional models focusing solely on psychiatric disorders are increasingly complemented by approaches that emphasise social determinants, developmental trajectories, and the lived experiences of young people and those who care for and support them [3,4].

One important development has been the expansion of qualitative research exploring how young people themselves understand and experience self-harm and suicidal thoughts. Such work highlights motivations that extend beyond clinical symptomatology, including emotional regulation, identity formation, interpersonal stress, and feelings of hopelessness or entrapment [5]. Another area of growing interest concerns the cognitive and motivational processes that may sustain self-harm behaviours. Emerging evidence suggests that self-harm may function as a coping strategy that provides short-term emotional relief or perceived reward, reinforcing the behaviour over time [6,7].

At the same time, there is increasing recognition of the broader social contexts shaping young people's mental health. Digital environments, gender expectations, educational pressures, and sociopolitical conditions can all influence experiences of distress and help-seeking. Reflecting these developments, the field has also placed greater emphasis on the

design and evaluation of early interventions, particularly in settings where young people first present in crisis, such as emergency departments, schools, and primary care [8–10].

The contributions to this Special Issue reflect these evolving priorities, offering insights that span individual psychological processes, lived experience, sociocultural context, and clinical response.

Contributions of the Special Issue

The eight papers in this Special Issue are best read not as isolated contributions, but as a connected body of work that advances the field across several levels of analysis: from the inner world of reward, motivation, and suicide rumination to the lived realities of young people in education and in families, to the wider social, cultural, and political conditions that shape risk, and finally to the question of what services can do, in practice, when young people present in crisis. In this sense, the Special Issue addresses self-harm and suicide in young people as both personal and structural phenomena, and as problems that demand simultaneous explanation, interpretation, and intervention.

Taken together, the eight papers build a picture of a field that is moving beyond single-cause explanations and towards a more layered understanding of self-injury and suicide in young people. The collection shows that these behaviours are shaped by disrupted motivational and cognitive processes, by relationships and institutional responses, by gendered and cultural expectations, by media ecologies, and by the larger sociopolitical conditions that determine whether young people experience their lives as viable and valued. Just as importantly, the Special Issue demonstrates that progress depends on methodological pluralism: qualitative work is needed to hear what distress feels like from the inside; quantitative work is needed to test pathways and moderators; theoretical work is needed to interpret rising risk in changing social contexts; and intervention research is needed to ensure that knowledge leads to better care.

Future Research Priorities

If this Special Issue shows anything clearly, it is that future research on self-harm in young people must become more integrative, more developmentally sensitive, and more structurally informed. The next phase of work in the field should not simply produce more studies of "risk factors" in the abstract. Rather, it should aim to explain how different forms of distress emerge, intensify, and are either mitigated or amplified across time, context, and systems of care.

First, there is a strong case for longitudinal and developmental research that can track the movement from distress to self-harm thoughts, from thoughts to acts, and from acts to repetition, recovery, or suicidal escalation. Several papers in this issue identify important pieces of the puzzle (reward processing, suicide rumination, hopelessness, stigma, and relational responses), but these are too often studied cross-sectionally or in isolation. Future studies should examine how these processes interact over time, and at what points intervention is most likely to alter trajectories. This is especially important in adolescence and emerging adulthood, when identities, relationships, and goals are changing rapidly and when self-harm may serve different functions at different developmental stages.

Second, future research should move decisively towards multi-level models of explanation. The field has made real progress in understanding individual-level correlates of self-harm and suicidality, but these alone are insufficient. The studies from Pakistan, Iraq, and the United States in particular make clear that structural adversity, gendered constraint, political climate, and social marginalisation are not secondary influences: they shape the very conditions under which despair becomes thinkable. A major priority, therefore, is to design research that can link subjective experience and clinical presentation with the wider determinants of mental health, including discrimination, educational exclusion, economic

https://doi.org/10.3390/healthcare14091151

insecurity, conflict, and policy change. The challenge for the field is not merely to "add context" but to theorise and measure how context enters into risk and resilience.

Third, there is a pressing need for more culturally grounded and globally diverse research. Much of the dominant literature on self-harm and suicide among young people still reflects evidence generated in a relatively narrow range of countries and service settings. This Special Issue shows the value of broadening that evidence base, but it also exposes how much remains to be done. Future work should not assume that models, measures, or interventions developed in one context will automatically transfer to another. Instead, research should investigate how local meanings of distress, family obligation, honour, shame, help-seeking, and gender shape both risk and response. Comparative and collaborative international studies would be especially valuable, provided they avoid reducing cultural differences into simple variables.

Future studies should take more seriously the role of institutions and service systems, not only individuals. The research in this Special Issue shows in different ways that responses from universities, clinicians, emergency departments, and carers can shape whether a young person feels understood, dismissed, contained, or abandoned. Research priorities should therefore include how schools, colleges, universities, emergency services, and community mental health systems identify risk, respond after self-harm or suicide attempts, involve families, and manage continuity of care. Intervention development also needs to include implementation questions from the outset: what is feasible, acceptable, equitable, and sustainable in routine care, not just under ideal trial conditions?

There is also a need for more co-produced and young people-led research. A field concerned with young people's survival and wellbeing should not routinely position them only as subjects (or participants) of study. Their involvement in framing research questions, interpreting findings, designing interventions, and shaping dissemination is essential if the work is to remain relevant and ethically grounded. This is particularly important in areas where adults' assumptions may obscure young people's realities, as the discourse analysis of media and self-harm usefully demonstrates. Co-production is not a methodological add-on; it is one route to producing knowledge that is less pathologising, more accurate, and more likely to improve support.

Finally, future research must engage more directly with the question raised most forcefully by Yen Li and colleagues: what makes life livable for young people [11]? The field has become adept at cataloguing risk, but prevention ultimately depends on more than identifying warning signs. It depends on understanding and strengthening the conditions that allow young people to experience belonging, dignity, safety, agency, and future possibility. That means studying protective environments as well as harmful ones; it means treating schools, communities, and policy contexts as sites of suicide prevention; and it means recognising that research on self-harm and suicide is inseparable from questions of justice. A stronger future agenda for the field will therefore be one that not only reduces harm but also helps build the social worlds in which young people can imagine staying alive.

Author Contributions: Writing—original draft preparation, J.B.; writing—review and editing, C.B. All authors have read and agreed to the published version of the manuscript.

Acknowledgments: We would like to thank all the authors who have contributed to this Special Issue.

Conflicts of Interest: The authors declare no conflict of interest.

References

1. Zhang, H.; Wang, T.Y.; Nan, J.; Jiang, H.; Chong, S.T.; Wang, Z.; Guo, J.; Chen, C. Global adolescent self-harm (10–19 years): 1990–2021 trends, health inequalities, frontier analysis, and 2035 projections using global burden of disease data. *Front. Public Health* **2026**, *14*, 1689706. [CrossRef] [PubMed]
2. Richardson, R.; Connell, T.; Foster, M.; Blamires, J.; Keshoor, S.; Moir, C.; Zeng, I.S. Risk and Protective Factors of Self-harm and Suicidality in Adolescents: An Umbrella Review with Meta-Analysis. *J. Youth Adolesc.* **2024**, *53*, 1301–1322. [CrossRef] [PubMed]
3. Hetrick, S.E.; Subasinghe, A.; Anglin, K.; Hart, L.; Morgan, A.; Robinson, J. Understanding the Needs of Young People Who Engage in Self-Harm: A Qualitative Investigation. *Front. Psychol.* **2020**, *10*, 2916. [CrossRef] [PubMed]
4. Llamocca, E.N.; Steelesmith, D.L.; Ruch, D.A.; Bridge, J.A.; Fontanella, C.A. Association Between Social Determinants of Health and Deliberate Self-Harm Among Youths with Psychiatric Diagnoses. *Psychiatr. Serv.* **2023**, *74*, 574–580. [CrossRef] [PubMed] [PubMed Central]
5. Simes, D.; Shochet, I.; Murray, K.; Sands, I.G. A Systematic Review of Qualitative Research of the Experiences of Young People and their Caregivers Affected by Suicidality and Self-harm: Implications for Family-Based Treatment. *Adolesc. Res. Rev.* **2022**, *7*, 211–233. [CrossRef]
6. Edmondson, A.J.; Brennan, C.A.; House, A.O. Non-suicidal reasons for self-harm: A systematic review of self-reported accounts. *J. Affect. Disord.* **2016**, *191*, 109–117. [CrossRef] [PubMed]
7. Mughal, F.; Chew-Graham, C.A.; Babatunde, O.O.; Saunders, B.; Meki, A.; Dikomitis, L. The functions of self-harm in young people and their perspectives about future general practitioner-led care: A qualitative study. *Health Expect.* **2023**, *26*, 1180–1188. [CrossRef] [PubMed] [PubMed Central]
8. Ramsay-Patel, T.; Chamberlain, S.R.; Grant, J.E.; Lochner, C.; Neufeld, S.A.S.; Wilkinson, P.O.; Ford, T.J.; Lutz, N.M. Nonsuicidal self-injury (NSSI) amongst LGBT+ young adults: The role of psychological distress. *J. Affect. Disord.* **2026**, *399*, 121027. [CrossRef] [PubMed]
9. Wen, X.; Sun, S.; Lin, D.; Yue, W.; Chen, R. A social ecological approach to social contagion of self-harm among young people. *Nat. Rev. Psychol.* **2025**, *4*, 718–736. [CrossRef]
10. WHO Regional Office for Europe. *Addressing the Digital Determinants of Young People's Mental Health and Well-Being: Web Annex: Findings from an Evidence Review and Policy Mapping*; License: CC BY-NC-SA 3.0 IGO; WHO Regional Office for Europe: Copenhagen, Denmark, 2025. Available online: https://iris.who.int/handle/10665/381480 (accessed on 31 March 2026).
11. Li, M.Y.; Mata, C.; Nathan, K. Is Life Unlivable for Youth in Post-DEI America?: Understanding Rising Suicide Rates Across Diverse Youth Groups Through Traditional Suicide Paradigms. *Healthcare* **2025**, *13*, 2585. [CrossRef]

healthcare

MDPI

Article

The Experience of Goals and Rewards in Young People Who Self-Harm: A Qualitative Exploration

Martina Di Simplicio [1,*], Ruksana Begum-Meades [1], Emily Gaardner-Bougard [1], Charis Eleftheriou [1], Oyinlola Akinsanya [1], Rachel Rodrigues [1,2], Lavanya Thana [1,3] and Lindsay H. Dewa [4]

[1] Division of Psychiatry, Department of Brain Sciences, Imperial College London, London W12 0NN, UK
[2] Division of Psychology and Language Sciences, University College London, London WC1E 6BT, UK
[3] NIHR Quality Safety and Outcomes Policy Research Unit, Yorkshire Quality and Safety Research Group, Bradford BD9 6RJ, UK
[4] School of Public Health, Imperial College London, London SW7 2AZ, UK
* Correspondence: m.di-simplicio@imperial.ac.uk

Highlights

What are the main findings?

- Young people who self-harm describe an experience of anticipating rewards and setting goals largely characterised by over-valuing conditional enjoyment and distant unachievable goals.
- Young people who self-harm do not find imagining goal achievement a motivational tool, but rather an unhelpful escapism.

What are the implication of the main findings?

- More research is needed to understand how an imbalance between short-term and long-term goals may contribute to maintaining vulnerability to self-harm behaviour in young people.
- Helping young people to develop more adaptive rewards and goals, and to use mental imagery to support motivation, may represent a novel target for intervention in self-harm.

Abstract

Background/Objectives. Self-harm is a heterogeneous behaviour with a lifetime prevalence of around 20% in young people aged 16–25 years old. Recent neurocognitive evidence suggests that, for some individuals, self-harm is associated with motivational processes similar to addiction, including maladaptive mental imagery, reward anticipation, and goal pursuit. However, our knowledge of young people's subjective experiences of rewards and goals in relation to self-harm behaviour remains limited. Our study aimed to investigate how young people who self-harm experience enjoying and wanting rewards and pursuing goals in daily life and whether this experience changes during periods of self-harm. We also explored their use of mental imagery as a key cognitive process to support motivation. **Methods.** We conducted two parallel focus groups online (total of N = 12) with young people (mean age = 12.2, SD = 3; nine women, two men, and one non-binary) with a past-year history of self-harm behaviour. Qualitative data was analysed using inductive thematic analysis. Two young people with lived experience of self-harm informed the topic guide and data interpretation. Examples of questions were "Do you think your experiences of enjoying and/or looking forward to pleasant things are related in any way to self-harm, or not?" and "Do you visualise things you enjoy or may look forward to? If you do, how is that experience?". **Results.** There were six themes: rewards need deserving, high self-standards,

keeping control, trapped into long-term goals, unhelpful mental imagery, and self-harm alters the experience and anticipation of rewards and goal attainment. Most young people reported enjoying conditional rewards and working towards long-term goals that tend to be unattainable and beyond their control. Imagining these goals was experienced as unhelpful by most. For all young people, periods of self-harm thwarted enjoyment and goal achievement, shifted the preference to short-term immediate gratification, including from self-harm behaviour, and devalued long-term goals. However, our data cannot determine if these experiences are specific to young people who self-harm. **Conclusions.** Our findings indicate that the reciprocal relationship between motivational processes and self-harm behaviour in young people warrants further investigation. Helping individuals develop more adaptive rewards and goals, including appreciation of short-term goals and use of motivational mental imagery, could represent valued support for young people with self-harm.

Keywords: self-harm; young people; goals; rewards; mental imagery

1. Introduction

Self-harm is defined as an act of self-injury or self-poisoning, regardless of intent [1]. It is a complex and heterogeneous behaviour that typically peaks in frequency around age 16 years old [2]. Prevalence has increased over the past 20 years, with approximately 20% of young people under the age of 25 reporting having self-harmed at some point in their life [3,4]. Self-harm significantly increases the risk of suicide above the presence of other factors, including psychopathology [5,6]. Psychological interventions can help reduce self-harm, but access to therapy is limited, and their effect is often small [7,8].

Based on a recent meta-analysis, the most frequently reported functions of self-harm are to regulate emotions (likely prevalence 63–78%) and to escape aversive affect (62–78%) [9]. Consequently, existing interventions, such as cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT), focus on improving emotion regulation and distress tolerance. However, it is well recognised that self-harm can also have other and multiple motives, including self-punishment (likely prevalence 41–62%) and communicating distress (30–55%) [9,10]. For some individuals, inducing a desired effect (42–57%) such as a sense of control, calm, or excitement can be an important driver of self-harm, leading to a positive reinforcement of the behaviour [11,12]. This highlights the need to personalise treatment to individual function(s) to improve outcomes [13,14].

The mechanisms maintaining self-harm may also be part of an addictive self-harm cycle [15,16], yet this is generally not considered in current treatments. Similarly to other addictive behaviours, the addictive experience of self-harm includes craving or urges to self-harm, anticipatory mental imagery related to urges, a loss of control over self-harm, increasing severity or frequency of self-harm over time, continuing despite negative consequences, and a cycle of abstinence and relapse [15,16].

The reward system is key in maintaining addictive behaviours [17,18] and is an area of interest in the maintenance of self-harm. Some studies have shown that at a neurocognitive level, differences in the processing of rewards (namely, anticipation synonymous with 'wanting' or craving, and consummation synonymous with 'liking' or enjoying rewards) are associated with self-harm thoughts and behaviour [19–21]. However, the theoretical implications of this are unclear. One hypothesis posits that a heightened neural consummatory response to rewards may contribute to engagement in risky behaviours such as self-harm, particularly in adolescence [19]. Another hypothesis, drawing on the addiction

literature [17,18], posits that a reduced neural response when anticipating common rewards such as money [20] may lead to seeking out other more salient rewards such as self-harm. This putative anticipatory neural bias may be secondary to concurrent depressive symptoms such as anhedonia but nevertheless represent a process that may directly contribute to maintaining self-harm in a similar way to an addiction [21].

Mental imagery is the experience of "seeing or hearing through the mind's eye" in the absence of an external sensory stimulus [22]. Imagining what one desires is a key component of motivational processes, i.e., of anticipating, wanting, and working towards rewards [22,23]. Mentally simulating enjoyable scenarios boosts anticipated pleasure [24] and impacts on actual behaviour [25,26]. On the other hand, poor reward-related mental imagery contributes to reduced effort towards achieving goals [27] and to depressive symptoms [28,29]. There is growing evidence that mental imagery of self-harm contributes to wanting to self-harm [30], similar to mental imagery of substances in addiction [31]. However, the motivational mental imagery of general rewards, of desired outcomes, and how to achieve these remains unexplored in relation to self-harm. Finally, difficulties in self-regulating goals, another process closely related to reward and motivation, are also present in individuals who self-harm [32,33]. Difficulties in vividly imagining enjoyable activities or the accomplishment of goals could hinder efforts at engaging in alternative behaviour to self-harm. Interestingly, positive mental imagery combined with goal-setting interventions in young people who self-harm can lead to improved emotional wellbeing and sense of control [34]. We have recently shown that motivational imagery of adaptive behaviours can reduce the frequency of self-harm [35,36] and improve goal achievement [37].

In summary, growing evidence suggests that dysfunctional motivational processes may be involved in self-harm behaviour and represent so far neglected therapeutic targets. While previous research has examined similarities between addiction and self-harm behaviour at the subjective level [38–40], the subjective experience of motivational processing (liking, wanting) in self-harm has not yet been investigated. Understanding how young people who self-harm experience everyday reward-processing and goal setting is key to (a) guide further mechanistic research and (b) ground intervention development in what is relevant to young people. This study aimed to explore how young people who self-harm anticipate and experience rewards, set goals, and experience goal pursuit. We also aimed to explore how young people use mental imagery to simulate rewards and goals, as mental imagery is a key cognitive process supporting motivation. Our research question was the following: how do young people who self-harm experience rewards and goals in their daily life?

2. Materials and Methods

2.1. Design

We adopted an interpretivist approach to gain an in-depth understanding of young people's views on reward and goal-pursuit behaviour in relation to their lived experiences of self-harm. However, we recognise that while we consciously endeavoured to keep an open stance, our approach was influenced by the quantitative neurocognitive research conducted by our team. Given the absence of previous qualitative studies on this specific topic and the heterogeneity of self-harm presentations, the choice of focus group format meant we could interact with participants and be exposed to different viewpoints, facilitating a broader exploration of themes and depth of discussion. The consolidated criteria for reporting qualitative research (COREQ) checklist guided our reporting.

2.2. Participants and Procedure

A purposive sample of participants from the experimental study IMAGINE investigating motivational biases in young people with self-harm were recruited (see details in Yavuz, Rodrigues et al., 2024 [41]). The IMAGINE study recruited young people from the general population aged 16–25, fluent in English language, and with at least one episode of self-harm within the past year. Exclusion criteria were current psychotic symptoms, acute severe suicidal ideation, or any severe neurological impairments. Young people who took part in the IMAGINE experimental session and consented to take part in qualitative focus groups were contacted via email and provided with a participant information sheet. None of the recruited participants were personally acquainted with the researchers who were present during the focus groups. Recruitment continued until an adequate number and diversity of representation (e.g., age, gender, and ethnicity) was achieved within the study time limits. A convenient day and time for the focus groups was then agreed among those who had expressed an interest. Written consent was taken electronically prior to the focus groups arranged date. Each participant was reimbursed GBP 40 for their time.

2.3. Topic Guide

Topic guide development was informed by a pre-registered systematic review (PROSPERO registration CRD42019132053) investigating the presence of reward processing in self-harm behaviour measured at cognitive, behavioural, and/or neurobiological level. First, a new search was conducted to look for relevant qualitative studies on reward processing in self-harm from three electronic databases (EMBASE, PsycINFO, and MEDLINE) on 21 March 2021 using the pre-registered criteria. Two independent raters (CE, OA) screened the result of the articles (inter-rater reliability = 82%) and extracted 19 qualitative papers for full-text screening. No paper addressed the pre-registered research question, "Do reward processing biases exist in self-harm?", and so no data extraction was conducted. Related concepts from the full-text papers and categories from the pre-registered review were then used to inform the nature of the questions and prompts in the topic guide. To minimise the risk of introducing bias derived from interest in reward processing and addiction models of self-harm, we deliberately refrained from directly asking participants about causal relations between motivational processes and self-harm. The topic guide was then reviewed, critiqued, and finalised by two members of a Young People Advisory Group (YPAG—see below), before being finalised for use in the focus groups (Table 1).

Table 1. Focus groups topic guide.

Enjoying and Looking Forward to Pleasant Things
What are some things you enjoy/that make you happy/that are important to you in your everyday life? How do those things make you feel? Why? Do you find things that other people tend to find rewarding such as praise, compliments, money, as rewarding or not? How do you feel about looking forward to pleasant things? Is there anything in particular, that you look forward to in the future or not? (in a few days/weeks/months/years) Do you think the experiences of enjoying and/or looking forward to pleasant things are related in any way to self-harm, or not? Have these experiences changed around periods when you were self-harming compared to periods when you weren't, or not?
Goals
Can you tell us about any goals you may have for the future? (tomorrow or in ten years' time) How is the experience of setting or achieving goals, if you do that? Why? Do you think the way you view your goals is related to self-harm or not?
Imagining goals and pleasant things
Can you tell us if you ever visualise things you enjoy or may look forward to? If you do, how is that experience? (e.g., frequency, feelings, consequences)

2.4. Data Generation

The number of participants was guided by thematic saturation [42], whilst also constrained by academic timelines. Thematic saturation was broadly reached, with recurring patterns around reward anticipation, goal-pursuit, and control consistently observed across participants in the two groups, ensuring sufficient depth and richness of data for the study's focused aims. Two parallel focus group discussions were conducted via Zoom in April 2021 to explore participants' subjective experiences of rewards, goal pursuit, and mental imagery in relation to self-harm. Each group participated in two 90 min sessions (S1 and S2) to cover the entire topic guide, allowing enough time for discussion. This method allowed participants to share and reflect on their experiences, consistent with the interpretivist aim of understanding meaning in context. Participants were allocated to Group 1 or 2 based on their time and date availability. We aimed for 6–8 participants per group [42], a sample size that would balance individual contribution with capturing a range of perspectives. Two participants invited to Group 2 did not attend S1, resulting in uneven numbers between the groups. Sessions were co-facilitated by CE, OA, and MDS, beginning with introductions and ground rules. Participants discussed their experiences, while facilitators prompted for depth and clarity. Non-verbal behaviours, tone, and emotions were noted for contextual insight (e.g., to assess relative agreement between participants around each sub-theme). All sessions were audio-recorded, transcribed verbatim, anonymised using participant IDs, and destroyed after transcription. Data handling followed GDPR guidelines to ensure confidentiality and ethical compliance.

2.5. Data Analysis

Data were analysed using reflexive thematic analysis following Braun & Clarke's updated guidance [43], emphasising reflexivity, rigorous coding, and transparency in the analytic process. Deductive elements informed by neurocognitive models of reward and motivation also influenced our final data interpretation. Transcripts were first read and re-read by the research team to ensure familiarisation with the content. Preliminary codes were then generated inductively from the raw data, capturing meaningful features of the discussions. Coding was carried out independently by two researchers (CE, OA), with discrepancies discussed until consensus was reached. Codes were collated into sub-themes, which were then conceptualised into tentative themes. These candidate themes were reviewed in collaboration with the two members of the YPAG and refined through iterative discussions with the full research team, enabling analyst triangulation and enhancing interpretive depth. Transcripts were not re-sent to participants for member checking.

Reflexivity was integral to the analytic process, particularly given that one member of the research team and two members of the YPAG were themselves young people with lived experience of self-harm. This positionality brought valuable insider insight into the language, context, and emotional tone of the discussions, supporting a more nuanced understanding of participants' accounts. At the same time, we discussed how shared experiences and similarities in age could introduce assumptions or unnoticed points of resonance that might shape interpretation of the data. In parallel, research team members contributed a clinical, psychiatric, and cognitive neuroscience perspective, offering insight into mental health, self-harm behaviours, and broader psychological/neurobiological frameworks. The combination of insider (lived experience) and professional perspectives allowed for a balanced interpretation, highlighting both contextual richness and theoretical relevance.

2.6. Patient and Public Involvement

Two young people with lived experience of self-harm informed the topic guide design and analysis research stages (two females, one BAME, one neurodivergent) via two meet-

ings lasting approximately 60 min, one prior to data collection (March 2021) and one after data coding (April 2021) on Microsoft Teams with members of the study team (MDS, CE and OA). The young people were members of the YPAG supporting the IMAGINE study (see Rodrigues et al., 2023 [44]), which had seven members in total recruited via social media and local networks and advised the study between 2018 and 2023 via online and in-person meetings.

3. Results

3.1. Sample

Twelve young people participated across two focus groups. Demographic characteristics are reported in Table 2. Mental health characteristics (depression scores and self-harm frequency) were collected during the IMAGINE study experimental session, which took place approximately 6–12 weeks prior to the focus groups, and so may not accurately reflect the experiences of the participants at the time of the focus groups.

Table 2. Participant characteristics.

Participant Number	Gender	Age	Ethnicity	Depression Scores	Self-Harm Frequency (Lifetime)	Self-Harm Frequency (Past Year)
1	W	20	Asian/Asian British	4	324	3
2	W	18	White	34	265	50
3	W	17	White	0	100	2
4	M	19	White	8	50	10
5	M	21	White	4	missing	missing
6	W	17	White	28	50	7
7	W	19	Arab	12	48	12
8	W	18	White	28	173	17
9	NB	25	White	22	Not sure	300
10	W	16	White	26	148	64
11	W	25	White	20	478	52
12	W	16	White	26	100	50

Twelve participants numbered 1–7 (n = 7) were part of focus Group 1 (G1). Participants numbered 8–12 (n = 5) were part of focus Group 2 (G2); F = female, M = male, NB = non-binary; DASS 21—Depression = Depression and Anxiety Stress Scale 21 (Normal = 0–9, Mild depression = 10–13, Moderate depression = 14–20, Severe depression = 21–27, Extremely severe depression = 28+); self-harm frequency = number of times self-harmed in the past year.

3.2. Themes

Six major themes were identified: rewards need deserving, keeping control, high self-standards, trapped into long-term goals, mental imagery of long-term goals not helpful, and self-harm alters the experience and anticipation of rewards and goals attainment. The themes are summarised together with sub-themes in Table 3 and conceptualised in a thematic map (Figure 1). Themes are illustrated with quotes below (P = Participant; G = Group; S = Session).

Table 3. Themes and sub-themes.

Theme	Sub-Themes
Rewards need deserving	Importance of being productive Unproductive enjoyments lead to temporary pleasure and negative feelings

Table 3. *Cont.*

Theme	Sub-Themes
Keeping control	Reward anticipation only for things under their control Short-term goals—more controllable Long-term goals—both more and less controllable
High self-standards	Ambitious, unattainable, unrealistic goals Perfectionism helps stay in control High standards can generate low motivation
Trapped into long-term goals	Short-term goals not rewarding Long-term goals are preferred, but more difficult to achieve and overwhelming Long-term goals can generate low motivation
Mental imagery of long-term goals not helpful	Imagery reinforces uncertainty, fear of failure, unattainability, and frustration around long-term goals Imagery as a form of escapism Imagery is a pleasant fantasy
Self-harm alters the experience and anticipation of rewards and goals attainment	Preference shifts to short-term goals Immediate gratification Usual enjoyable activities are no longer rewarding Low motivation Self-harm becomes the goal

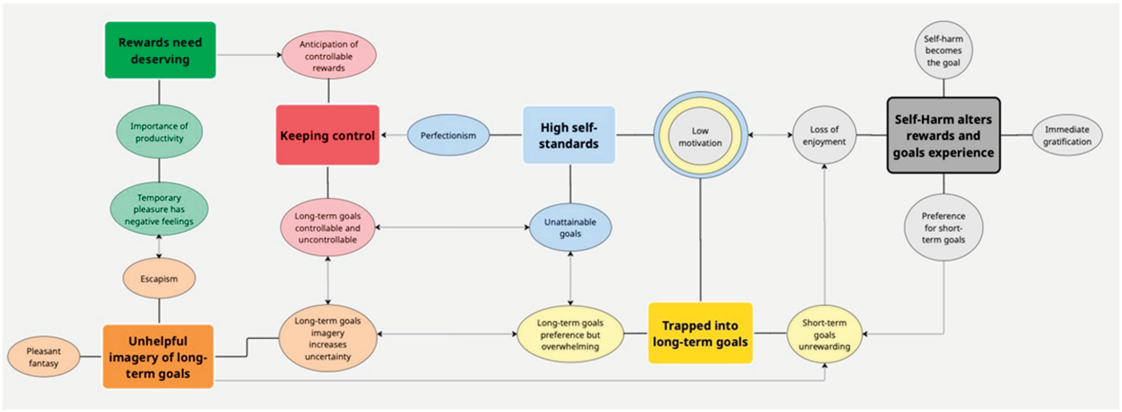

Figure 1. Thematic map illustrates how different themes and sub-themes are connected to form young people's experience of rewards and goals, and how this is perceived to change in relation to self-harm. Themes are in rectangular boxes, with respective sub-themes in oval boxes of the same colour. Low motivation sub-theme has multiple colours to indicate that it is repeated across three themes. Continuous lines connect each theme with its sub-themes. Thin lines depict links between different themes and their sub-themes, with arrows suggesting directionality of the link. E.g., Undervaluing short-term goals may contribute to loss of enjoyment when short-term goals are preferred; if imagery increases sense of uncertainty around long-term goals, it may also increase the perception that long-term goals are overwhelming. Conversely, imagery may be unhelpful because imagined long-term goals are uncontrollable and overwhelming.

3.2.1. Theme 1: Rewards Need Deserving

All participants were able to describe things that they enjoy and consider rewards, such as activities and hobbies. In particular, gaining a reward because of their own productivity and hard work provided all participants with feelings of satisfaction and gratification. In contrast, most participants expressed guilt for enjoying a reward (like a compliment or money) if they felt they did not deserve it or had not earned it.

> *"If I just do something I enjoy without doing something productive, you could say, it would be at the back of my head that I'm doing something, but I shouldn't be doing it…"*
>
> (P5, G1, S1)

A few participants went all the way to describe activities which might have been experienced as temporarily enjoyable (such as watching videos on YouTube or TV series) as unproductive "avoidance behaviours", ultimately associated with negative emotions. However, a few others disagreed with the need to deserve rewards to enjoy them.

> *"When it [the enjoyable activity] is a bit more avoidance it feels good at the time but not really like after"*
>
> (P9, G2, S1)

> *"Nah (laughs) I just feel like it's a tough life and you have to have nice things and do things that make you happy. You deserve it regardless."*
>
> (P1, G1, S1)

3.2.2. Theme 2: Keeping Control

For most participants, perceived control over future rewards was very important. For some, when they felt a lack of control over a future reward or goal, this had the potential to generate negative reactions, such as feeling anxious. For others, having no control over delayed gratification led to feeling stressed. Consequently, these participants expressed only anticipating future rewards if they felt that they had control over obtaining them.

> *"I just really think it [looking forward to something] depends on how much in control of this thing I am and how much certainty there is because I find it really hard with like kind of unpredictable, uncertain things"*
>
> (P9, G2, S1)

> *"If I really am looking forward to it then I want it sooner like really badly—I'm not prepared to wait kind of thing so it can be quite uncomfortable and quite stressful if it is quite far away."*
>
> (P3, G1, S1)

The need for control translated into varying attitudes towards short-term (usually more controllable) vs. long-term anticipated rewards. Short-term rewards felt more controllable to some participants: these would be more mundane events (like seeing friends or receiving a parcel), leaving space for excitement and positive anticipation. In contrast, long-term rewards and goals were described more in the domains of "life goals", and their uncertainty was perceived by most as less controllable and anxiety-provoking. However, a few participants viewed this uncertainty also as offering a chance of exerting some control and shaping the future.

> *"I look at like what I have next week to look forward to because I'm really scared of the future. So next week, even if it's like going out with friends, I'd look forward to that, but I'm not really like far-fetched."*
>
> (P3, G1, S1)

> *"I look forward to things much further into the future maybe because it's uncertain so I can just shape it however I want"*
>
> (P7, G1, S1)

3.2.3. Theme 3: High Self-Standards

Most participants reported a tendency for high self-standards, which translated into goals that were described as too many, unrealistic, all-or-nothing, and overwhelming. A few termed the high standards perfectionism and saw it as leading to positive experiences and achievements. Most participants, however, mentioned the potential negative impact of their high standards on their own motivation and the ability to put effort into achieving a

goal. Participants expressed a consensus that high standards could deplete energies and have a downstream negative effect on general mental health.

> *"My experience of goals is difficult because I set myself extremely unrealistic goals and then destroy myself trying to get to them"*
>
> (P10, G2, S2)

> *"I set all these goals and didn't do anything so I sort of blame myself because I'm not doing these goals, I'm not progressing so it's kind of a negative thing in a way, too many goals"*
>
> (P5, G1, S2)

3.2.4. Theme 4: Trapped into Long-Term Goals

All participants were able to identify goals and how both setting and pursuing them can be affected by internal factors including mood, fear of failure, and external factors such as sharing a collective goal (e.g., preparing an exam) or receiving other people's validation (e.g., parents' feedback or a good mark). Most participants tended to dismiss short-term goals and their ability to produce any sense of reward. This was explained as the small steps leading to a bigger goal not counting as sources of gratification or anticipation.

> *"I just don't view anything short-term as valuable, it's like always working towards the next big thing"*
>
> (P10, G2, S2)

> *"I reckon the term goals is something a bit bigger so just like P5 and P2 said with having a to do list. I'm not gonna call them 'small goals'."*
>
> (P1, G1, S2)

All participants described that long-term goals such as career or relationship aspirations were the important and rewarding ones. However, all also noted that the pursuit of long-term goals could generate a sense of being exhausted and overwhelmed because these goals are big, important, and cannot be achieved quickly. For some participants, this meant they lost motivation towards long-term goals due to their unattainability or to the absence of immediate gratification. Only a few participants described turning to pursuing short-term goals.

> *"A lot of the time when I'm setting big goals, I become unmotivated because it seems so overwhelming like for example, I wanted to be a clinical psychologist since like sixth form but because it was so overwhelming and such a big thing, I became so overwhelmed and just didn't want in the end, so I lost sight of that goal"*
>
> (P2, G1, S2)

> *"Because a long-term goal just seems so unachievable, I just sort of ignore them and they no longer feel like goals [be]cause there is like no clear plan to work towards them so I kind of prefer short term goals"*
>
> (P7, G1, S2)

3.2.5. Theme 5: Mental Imagery of Long-Term Goals Not Helpful

Two participants reported never visualising things in their mind. All other participants described imagining long-term (rather than short-term) rewarding scenarios and goals. For them, imagining long-term goals was potentially distressing because it amplified the sense of uncertainty and unattainability, fear of failure, and feelings of sadness or frustration for "not getting there". Most participants viewed imagining achieving goals as a form of escapism not conducive to goal attainment, and some participants explicitly named positive mental imagery as wasting time instead of finding a solution to one's problems.

> *"When I imagine positive things, it's like things very distant in the future, like whether it's my dream career or having a house"*
>
> (P7, G1, S2)

> *"I agree it makes me feel sad and overwhelmed and it's almost like this is how life could be and you've made some rubbish choices so you're never gonna get there so it actually makes me feel a bit rubbish"*
>
> (P11, G1, S2)

While agreeing with the above, a few participants also reported that at times, picturing future goals in their mind was pleasant or comforting. These participants described that simulating desired scenarios would be helpful to lift mood temporarily, to feel prepared, or to increase motivation. However, they also experienced that the positive effects of imagery did not last or elicited ambivalent feelings.

> *"So when I do my whole like, rehearsing-imagining that feels like it's actually really productive because I feel like I've prepared myself for something so that I definitely feel a sense of reward."*
>
> (P9, G2, S2)

> *"It feels comforting and enlightening but also sad for me because I'm like I don't know if I'll ever get there"*
>
> (P1, G1, S2)

3.2.6. Theme 6: Self-Harm Alters the Experience and Anticipation of Rewards and Goal Attainment

During periods of self-harm, some participants described losing the ability to enjoy or to look forward to things they usually find pleasant. Some participants reported that activities that are usually enjoyable and typically used as positive coping mechanisms were no longer pleasant, as they required effort that would not pay off and/or did not provide immediate gratification. The latter experience translated for some into seeking more gratifying rewards from more energetic, harder to achieve, or more intense activities.

> *"I feel like nothing could cheer me up [during times of self-harm] I guess you could say"*
>
> (P5, G1, S1)

> *"When I'm really not feeling great I struggle to be patient and I just feel like I need to feel different right now and that's why I find it much harder to get myself to engage in these positive things cause I know that it will be effort and I won't necessarily get something back for my effort straight away."*
>
> (P12, G2, S1)

All participants agreed that in periods of more frequent self-harm, goals would shift from long-term to short-term. For some participants, the focus on short-term goals was seen as a means of survival; for others, it reflected instead the search for immediate gratification. Most participants explicitly mentioned low mood as an important concurrent factor with self-harm that influenced seeking immediate rewards. Participants referenced the previous discussion around long-term goals and expressed how low motivation made them refocus on short-term goals. In this context, a few reported the use of positive imagery of the future to alleviate negative affect, framed as an escape from the difficult reality.

> *"Erm, yeah, I think I would choose things that provide a lot of gratification but don't require much effort. Other times, simple tasks that make me feel like I've achieved something like a short workout or doing groceries—something you can tick off a list or*

you know, I don't tend to focus on long-term goals. They just seem unachievable, and I'm not motivated towards achieving them"

(P5, G1, S2)

"Yeah, I would discard the long-term goals and focusing on the short-term ones, so you feel like the effects quicker—so more like a to-do list like we said earlier"

(P3, G1, S2)

Some participants also reflected that self-harm could become the epicentre of goal pursuit, either to obtain the reward from self-harm or to stop self-harming.

"Rather than looking forward to things in the future, it would always be looking forward to my next incident of self-harm."

(P2, G1, S1)

"I would only have one goal—don't cut"

(P8, G2, S2)

4. Discussion

Our study examined for the first time the subjective experience of rewarding activities and goal pursuit in young people who self-harm, with a particular interest in the use of mental imagery. Young people expressed six main themes: rewards need deserving, keeping control, high self-standards, trapped into long-term goals, mental imagery of long-term goals not helpful, and self-harm alters the experience and anticipation of rewards and goals pursuit. We found that overall young people with self-harm looked forward to and enjoyed rewards in their daily lives. However, anticipation and enjoyment tended to be conditional on productivity and a sense of control over obtaining rewards. Young people with self-harm often worked towards goals that they perceived as unattainable, while paradoxically also reporting a need for control over these goals. Long-term goals were preferred over short-term ones; however, this preference was reported to shift during periods of self-harm, with the desire for immediate gratification becoming clearer. The use of mental imagery appeared to be limited to anticipating long-term goals and was largely reported as being unhelpful and, at times, distressing.

Young people in our study did not report any difficulty in anticipating or embracing (wanting and liking) rewarding experiences in their day-to-day lives. However, during periods of self-harm, they reported a lack of motivation and inability to enjoy or look forward to pleasant experiences, which they associated with depressed mood, consistent with previous literature on future-thinking, reward, and motivational biases in depression [45–48]. These findings are in line with experimental and neurobiological evidence showing individuals who self-harm have a typical or enhanced response to consummation of rewards [19,49–52], and that reduced anticipation of rewards in those with self-harm is associated with depressive symptoms [20]. Critically, however, any association between this reward bias and craving for self-harm at the subjective level was unclear from our findings and should be explored in future studies.

Another characteristic endorsed by most participants was the dismissal of temporary, short-term rewards, which could instead generate distress unless perceived as "productive". The need for deserving rewards may reflect the ubiquitous emphasis on productivity in Western culture beyond any association with poor mental health or self-harm. Low self-esteem, poor self-compassion, and self-punishment are often endorsed by young people who self-harm [53] and may also drive this refusal of purely hedonistic or fortuitous gratifying experiences. In contrast, during periods of self-harm, participants' focus shifted to short-term goals as a means of survival to get through the day or avoid self-harming,

while working towards long-term goals became less relevant. However, some previously rewarding activities (e.g., going for a walk) became less appealing if they required effort or if they lacked intensity, suggesting that the shift to small achievable goals during periods of poor mental health does not always focus on adaptive behaviour in young people with self-harm. In fact, for some young people, self-harming would become the only achievable and overwhelming goal in their day.

Another theme expressed by participants was the importance of perceived control over rewards and goals. Having an external locus of control, whereby an individual believes their actions and environment are determined by external forces, has been described as a personality trait characteristic of individuals who self-harm in correlational studies [54,55]. It may be that young people in our study expressed the need to be in control to counteract an external locus of control. Similarly, the need to regain control is often described as a driver of self-harm as part of emotion regulation [56,57]. However, previous neurobiological research has also suggested that control enhances the activation of reward processing regions in the brain [58,59]. Future research could elucidate whether the need for control is a generalised trait or an automatic mechanism to heighten blunted reward anticipation in this population [20].

The theme of high standards and perfectionism has previously been associated with self-harming behaviour [60]. In our findings, this trait appears to drive the focus towards ambitious goals that are nonetheless perceived as unattainable, consistent with previous research in cohorts of self-harming adolescents [61,62]. It is possible that goals are perceived as unattainable due to self-criticism [62], pessimistic biases [63,64] and low self-efficacy [65], all strongly associated with poor mental health [66] and not necessarily specific to self-harm. However, the combination of high standards, low attainability, and overvaluation of long-term goals may lead to feeling trapped, one of the key motivational factors in the Integrated Motivational Volitional model of self-harm [67]. For example, some participants described 'painful engagement', i.e., the inability to relinquish unattainable goals, which can compromise motivation for new goals [64]. Young people in our study expressed the pitfalls of pursuing long-term goals, including overwhelm and exhaustion [63,66]. However, they appeared to dismiss short-term goals outside of periods of self-harm and also denied imagining short-term goals. It would be important to understand if and how lack of mental imagery and devaluation of short-term goals are related, and if they are typical of those who self-harm, given evidence from the general population that adolescents may be more sensitive to immediate, short-term rewards compared to long-term goal setting [68].

Critically, for young people with self-harm, the use of mental imagery was limited to distant goals and was overall found unhelpful and distressing as it amplified the sense of uncertainty and unattainability. A previous qualitative study described that adolescents with anhedonia have difficulties imagining pleasurable events in the near future but still look forward to distant goals [69]. Among our participants, even when imagery conveyed anticipated pleasure and satisfaction, it appeared to subsequently generate the cognitive dissonance between present and desired self [70] or was viewed by most as merely escapism. However, it is possible that undetected aphantasia within the sample and/or effects of age on the ability to generate complex mental imagery (which may be underdeveloped in adolescents) skewed our findings [71]. As mental simulation of proximal activities contributes to adaptive planning and motivation [72–74], future studies should test whether a lack of effective future goal-attainment imagery directly impacts reduced goal specificity, goal expectancy, low motivation, and effort towards goal achievement reported in individuals with self-harm [63,75]. When reducing self-harm is a goal, the development of adaptive goal-directed motivational imagery could then represent an important target for intervention in this population, as suggested by initial findings from our

Imaginator studies [35–37]. Crucially, Imaginator focuses on proximal rewarding goals that offset an individual's specific function of self-harm.

4.1. Strengths and Limitations

A key strength was that we built qualitative research questions on a systematic review framework (https://www.crd.york.ac.uk/PROSPERO/view/CRD42019132053, accessed on 14 December 2025) and with lived experience input, directly seeking to add rich qualitative insight to previously conducted quantitative studies in this area. The involvement of multiple analysts and iterative review of themes ensured that insider perspectives and professional expertise enriched, rather than constrained, the transparency and rigour of our analysis. In terms of limitations, some participants may have withheld sensitive information in a group setting. For some young people who reported a low past-year frequency of self-harm compared to lifetime, the discussion had a largely retrospective nature, which could have led to recall bias. Moreover, focus groups were conducted in 2021, during the COVID-19 pandemic, which may limit the generalisability of findings. The group spanned 16–25 years of age, which made it hard to account for possible developmental confounders, due to neurocognitive maturation and to growing autonomy, e.g., in shaping one's goals in older compared to younger participants. It is likely that differences in age, gender, imagery ability (including possible aphantasia), varying levels of both current and past depression and self-harm behaviour influenced the group discussions. A sophisticated analysis of the interaction between individual characteristics, group dynamics, and theme generation could further enrich the interpretation of our findings. As noted above, a main limitation of our findings is that while our topic guide tried to separate general experience and to capture trait-level biases from experience directly related to self-harm, these were hard to disentangle, as was the impact of concurrent depression. It would be important to extend our findings by asking about periods of other dominant affective states (anxiety, irritability) that are often associated with self-harm, and by conducting focus groups with young people with depression but no concurrent self-harm, as well as without mental health difficulties. It is also possible that different study designs are better suited to disentangle these associations, such as ecological momentary assessment studies, in which variations over time in affect, behaviour, and motivational processes could be modelled. Other limitations included researcher bias (e.g., all female researchers) and the fact that, as this was a student project, we were not able to involve lived-experience co-researchers in all stages of the research [76].

4.2. Future Research and Clinical Implications

Our results indicate that interventions that enhance savouring and general future-orientation may only be relevant when self-harm presents in the context of depression and, in particular, anhedonia. Rather than learning to simply enjoy positive emotions, young people with self-harm may benefit from focusing on rewards that originate outside one's control, such as an unexpected compliment or a lucky event, and this may be as important as learning to manage negative emotions. Our findings also suggest that improving the ability to feel in control via alternative rewarding behaviours may represent a valuable target for treatment for individuals whose self-harm is motivated by gaining control.

Future research needs to better explore the reciprocal relationship between short-term and long-term goal pursuit processes, mental imagery, and changes in self-harm behaviour and mood. Namely, self-harm could be maintained by devaluing short-term goals when euthymic and/or devaluing long-term goals when low. Overall, it is possible that developing the ability to value and be satisfied by achievable short-term goals that are in one's control might represent an important preventative target for this population during

periods of relative stability. On the other hand, during periods of self-harm, therapeutic interventions may focus on identifying adaptive short-term goals, as already included in some CBT protocols [77]. Training how to modulate motivational mental imagery to serve different goal timeframes could represent an innovative intervention in keeping with the recent growth of imagery-based therapies [35,77–79].

5. Conclusions

In summary, our study suggests that the experience of rewards and goals in young people who self-harm warrants better investigation. Future research should understand if the need for control over rewards and goals, under- and over-valuation of short vs. long-term goals, and poor use of motivational mental imagery processes is driven largely by concurrent depression and how it impacts on actual self-harm. A better comprehension of these subjective experiences and the underlying cognitive mechanisms could open novel areas of support for young people both in crisis and in routine clinical management.

Author Contributions: Conceptualization, M.D.S., R.R., L.T. and L.H.D.; methodology, M.D.S., R.R., L.T. and L.H.D.; data collection, C.E. and O.A.; data analysis, C.E., O.A., L.T. and L.H.D.; data interpretation C.E., O.A., M.D.S., R.R., L.T. and L.H.D.; writing—original draft preparation, M.D.S., E.G.-B. and R.B.-M.; writing—review and editing, M.D.S., R.R., O.A., R.B.-M. and L.H.D. All authors have read and agreed to the published version of the manuscript.

Funding: This work was supported by the Imperial NIHR BRC (Award P78558 to Dr Di Simplicio). This paper presents independent research funded by the Imperial NIHR BRC and supported by the NIHR CRF at Imperial College Healthcare NHS Trust. The views expressed are those of the authors and not necessarily those of the Imperial NIHR BRC, the NHS, the NIHR, or the Department of Health.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the NRES Committee South Central Oxford-C (REF: 19/SC/0275, 14 September 2022).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study are available on request from the corresponding author due to confidentiality/data protection reasons by the ethics protocol under which the data was collected.

Acknowledgments: We thank Emily M and Nusaybah C, members of the Young People Advisory Group, for their valuable insight and work on this research.

Conflicts of Interest: The authors declare no conflicts of interest. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

References

1. NICE. National Institute for Health and Care Excellence. NICE. 2013. Available online: https://www.nice.org.uk/guidance/qs34 (accessed on 14 December 2025).
2. Gillies, D.; Christou, M.A.; Dixon, A.C.; Featherston, O.J.; Rapti, I.; Garcia-Anguita, A.; Villasis-Keever, M.; Reebye, P.; Christou, E.; Al Kabir, N.; et al. Prevalence and characteristics of self-harm in adolescents: Meta-analyses of community-based studies 1990–2015. *J. Am. Acad. Child Adolesc. Psychiatry* **2018**, *57*, 733–741. [CrossRef] [PubMed]
3. Swannell, S.V.; Martin, G.E.; Page, A.; Hasking, P.; St John, N.J. Prevalence of Nonsuicidal Self-Injury in Nonclinical Samples: Systematic Review, Meta-Analysis and Meta-Regression. *Suicide Life-Threat. Behav.* **2014**, *44*, 273–303. [CrossRef]
4. Pisinger, V.S.; Hawton, K.; Tolstrup, J.S. School-and class-level variation in self-harm, suicide ideation and suicide attempts in Danish high schools. *Scand. J. Public Health* **2019**, *47*, 146–156. [CrossRef]
5. Chan, M.K.Y.; Bhatti, H.; Meader, N.; Stockton, S.; Evans, J.; O'Connor, R.C.; Kapur, N.; Kendall, T. Predicting suicide following self-harm: Systematic review of risk factors and risk scales. *Br. J. Psychiatry* **2016**, *209*, 277–283. [CrossRef]

6. Hawton, K.; Bergen, H.; Cooper, J.; Turnbull, P.; Waters, K.; Ness, J.; Kapur, N. Suicide following self-harm: Findings from the Multicentre Study of self-harm in England, 2000–2012. *J. Affect. Disord.* **2015**, *175*, 147–151. [CrossRef]
7. Ougrin, D.; Tranah, T.; Stahl, D.; Moran, P.; Asarnow, J.R. Therapeutic interventions for suicide attempts and self-harm in adolescents: Systematic review and meta-analysis. *J. Am. Acad. Child. Adolesc. Psychiatry* **2015**, *54*, 97–107. [CrossRef] [PubMed]
8. Torralba-Suarez, C.; Olry-de-Labry-Lima, A. An umbrella review of cognitive Behavioural and dialectical Behavioural therapies to treat self-harm and suicidal behaviour in adolescents. *Actas Esp. Psiquiatr.* **2024**, *52*, 549. [CrossRef] [PubMed]
9. Taylor, P.J.; Jomar, K.; Dhingra, K.; Forrester, R.; Shahmalak, U.; Dickson, J.M. A meta-analysis of the prevalence of different functions of non-suicidal self-injury. *J. Affect. Disord.* **2018**, *227*, 759–769. [CrossRef]
10. Edmondson, A.J.; Brennan, C.A.; House, A.O. Non-suicidal reasons for self-harm: A systematic review of self-reported accounts. *J. Affect. Disord.* **2016**, *191*, 109–117. [CrossRef]
11. Bryant, L.D.; O'Shea, R.; Farley, K.; Brennan, C.; Crosby, H.F.; Guthrie, E.; House, A. Understanding the functions of repeated self-harm: A Q methodology approach. *Soc. Sci. Med.* **2021**, *268*, 113527. [CrossRef]
12. Mughal, F.; Chew-Graham, C.A.; Babatunde, O.O.; Saunders, B.; Meki, A.; Dikomitis, L. The functions of self-harm in young people and their perspectives about future general practitioner-led care: A qualitative study. *Health Expect.* **2023**, *26*, 1180–1188. [CrossRef] [PubMed]
13. Moran, P.; Chandler, A.; Dudgeon, P.; Kirtley, O.J.; Knipe, D.; Pirkis, J.; Sinyor, M.; Allister, R.; Ansloos, J.; A Ball, M.; et al. The Lancet Commission on self-harm. *Lancet* **2024**, *404*, 1445–1492. [CrossRef]
14. Copsey, B.; Wright-Hughes, A.; Farrin, A.; Gates, C.; Farley, K.; Brennan, C.; McMillan, D.; Graham, C.D.; Bojke, C.; Mattock, R.; et al. Results of a feasibility study of the FReSH START intervention to improve quality of life and other outcomes in people who repeatedly self-harm (Function REplacement in repeated Self-Harm: Standardising Therapeutic Assessment and the Related Therapy). *Pilot. Feasibility Stud.* **2025**, *11*, 67. [CrossRef]
15. Carenys, A.Z.; Adan, A. Non-Suicidal Self-Injury as a Behavioural Addiction: A Systematic Review. *Curr. Addict. Rep.* **2025**, *12*, 67. [CrossRef]
16. Witcher, M.; Rowe, S.; Marlow, S.; Heath, J. Exploring the addictive processes in repetitive self-harm through a grounded theory approach: "It always felt like a choice until it didn't". *PLoS ONE* **2025**, *20*, e0328914. [CrossRef]
17. Robinson, M.J.F.; Fischer, A.M.; Ahuja, A.; Lesser, E.N.; Maniates, H. Roles of "wanting" and "liking" in motivating behavior: Gambling, food, and drug addictions. *Behav. Neurosci. Motiv.* **2015**, *27*, 105–136.
18. Thomsen, K.R.; Fjorback, L.O.; Møller, A.; Lou, H.C. Applying incentive sensitization models to behavioral addiction. *Neurosci. Biobehav. Rev.* **2014**, *45*, 343–349. [CrossRef]
19. Poon, J.A.; Thompson, J.C.; Forbes, E.E.; Chaplin, T.M. Adolescents' Reward-related Neural Activation: Links to Thoughts of Nonsuicidal Self-Injury. *Suicide Life-Threat. Behav.* **2019**, *49*, 76–89. [CrossRef]
20. Tsypes, A.; Owens, M.; Hajcak, G.; Gibb, B.E. Neural reward responsiveness in children who engage in nonsuicidal self-injury: An ERP study. *J. Child. Psychol. Psychiatry* **2018**, *59*, 1289–1297. [CrossRef]
21. Sauder, C.L.; Derbidge, C.M.; Beauchaine, T.P. Neural responses to monetary incentives among self-injuring adolescent girls. *Dev. Psychopathol.* **2016**, *28*, 277–291. [CrossRef] [PubMed]
22. Cocquyt, C.M.; Palombo, D.J. Emotion in the mind's eye: Imagination for adaptive cognition. *Ann. N. Y. Acad. Sci.* **2023**, *1526*, 59–72. [CrossRef]
23. May, J.; Andrade, J.; Kavanagh, D.J. An Imagery-Based Road Map to Tackle Maladaptive Motivation in Clinical Disorders. *Front. Psychiatry* **2015**, *6*, 14. [CrossRef]
24. Linke, J.; Wessa, M. Mental imagery training increases wanting of rewards and reward sensitivity and reduces depressive symptoms. *Behav. Ther.* **2017**, *48*, 695–706. [CrossRef]
25. Ji, J.L.; Geiles, D.; Saulsman, L.M. Mental imagery-based episodic simulation amplifies motivation and behavioural engagement in planned reward activities. *Behav. Res. Ther.* **2021**, *145*, 103947. [CrossRef]
26. Renner, F.; Murphy, F.C.; Ji, J.L.; Manly, T.; Holmes, E.A. Mental imagery as a "motivational amplifier" to promote activities. *Behav. Res. Ther.* **2019**, *114*, 51–59. [CrossRef] [PubMed]
27. Pillny, M.; Schlier, B.; Lincoln, T.M. "I just don't look forward to anything". How anticipatory pleasure and negative beliefs contribute to goal-directed activity in patients with negative symptoms of psychosis. *Schizophr. Res.* **2020**, *222*, 429–436. [CrossRef] [PubMed]
28. Dean, R.L.; Orchard, F.; Pile, V.; Lester, K.J. "When I picture myself, I just see black and white and dull": A photo-elicitation study exploring mental images of the self in young people with depression. *BMC Psychiatry* **2025**, *25*, 642. [CrossRef] [PubMed]
29. Anderson, R.J.; Clayton McClure, J.H.; Boland, J.; Howe, D.; Riggs, K.J.; Dewhurst, S.A. The relationship between depressive symptoms and positive emotional anticipation of goal achievement. *J. Exp. Psychopathol.* **2023**, *14*. [CrossRef]
30. Ji, J.L.; Kyron, M.; Saulsman, L.; Becerra, R.; Lin, A.; Hasking, P.; Holmes, E.A. Picturing self-harm: Investigating flash-forward mental imagery as a proximal and modifiable driver of non-suicidal self-injury. *Suicide Life Threat. Behav.* **2024**, *54*, 713–727. [CrossRef]

31. Månsson, V.; Andrade, J.; Jayaram-Lindström, N.; Berman, A.H. "I see myself": Craving imagery among individuals with addictive disorders. *J. Addict. Dis.* **2023**, *41*, 64–77. [CrossRef]
32. O'Connor, R.C.; O'Carroll, R.E.; Ryan, C.; Smyth, R. Self-regulation of unattainable goals in suicide attempters: A two year prospective study. *J. Affect. Disord.* **2012**, *142*, 248–255. [CrossRef]
33. Vincent, P.J.; Boddana, P.; MacLeod, A.K. Positive life goals and plans in parasuicide. *Clin. Psychol. Psychother. Int. J. Theory Pract.* **2004**, *11*, 90–99.
34. Hasking, P.; Whitlock, J.; Voon, D.; Rose, A. A cognitive-emotional model of NSSI: Using emotion regulation and cognitive processes to explain why people self-injure. *Cogn. Emot.* **2017**, *31*, 1543–1556. [CrossRef]
35. Di Simplicio, M.; Appiah-Kusi, E.; Wilkinson, P.; Watson, P.; Meiser-Stedman, C.; Kavanagh, D.J.; Holmes, E.A. Imaginator: A proof-of-concept feasibility trial of a brief imagery-based psychological intervention for young people who self-harm. *Suicide Life-Threat. Behav.* **2020**, *50*, 724–740. [PubMed]
36. Servi, A.; Gardner-Bougaard, E.; Jabril Mohamed, S.; McDermott, A.C.; Chowdury, N.; Dewa, L.; Di Simplicio, M. IMAGINATOR 2.0: Co-design and early evaluation of a novel blended digital intervention targeting self-harm in young people. *medRxiv* **2025**, *preprint*. [CrossRef]
37. Dewa, L.H.; Servi, A.; Gardner-Bougaard, E.; Jabril Mohamed, S.; McDermott, A.; Nusaybah, C.; Aveyard, B.; Rodrigues, R.; Hampshire, A.; Van Zalk, N.; et al. Exploring the acceptability and feasibility of a blended imagery-based digital intervention for self-harm in young people (Imaginator 2.0): A co-produced qualitative study. *medRxiv* **2025**, *preprint*. [CrossRef]
38. Nixon, M.K.; Cloutier, P.F.; Aggarwal, S. Affect regulation and addictive aspects of repetitive self-injury in hospitalized adolescents. *J. Am. Acad. Child. Adolesc. Psychiatry* **2002**, *41*, 1333–1341. [CrossRef]
39. Miller, M.; Redley, M.; Wilkinson, P.O. A qualitative study of understanding reasons for self-harm in adolescent girls. *Int. J. Environ. Res. Public Health* **2021**, *18*, 3361. [CrossRef]
40. Himelein-Wachowiak, M.; Giorgi, S.; Kwarteng, A.; Schriefer, D.; Smitterberg, C.; Yadeta, K.; Bragard, E.; Devoto, A.; Ungar, L.; Curtis, B. Getting "clean" from nonsuicidal self-injury: Experiences of addiction on the subreddit r/selfharm. *J. Behav. Addict.* **2022**, *11*, 128–139. [CrossRef]
41. Yavuz, E.; Rodrigues, R.; Pascual Sanchez, A.; Lingford-Hughes, A.; Di Simplicio, M. Reward processing in young people with self-harm behaviour. *J. Psychiatr. Res.* **2024**, *180*, 68–78. [CrossRef]
42. Hennick, M. *International Focus Group Research: A Handbook for the Health and Social Sciences*; Cambridge University Press: Cambridge, UK, 2007; pp. 135–151. [CrossRef]
43. Braun, V.; Clarke, V. Conceptual and design thinking for thematic analysis. *Qual. Psychol.* **2022**, *9*, 3–26. [CrossRef]
44. Rodrigues, R.; Mehesz, E.Z.; Lingford-Hughes, A.; Di Simplicio, M. Approach-avoidance biases to self-harm cues in young people with self-harm. *J. Affect. Disord.* **2023**, *340*, 435–441. [CrossRef]
45. Hallford, D.J. The phenomenological characteristics of autobiographical future thinking in dysphoric and non-dysphoric individuals. *Psychiatry Res.* **2019**, *273*, 481–486. [CrossRef] [PubMed]
46. Horne, S.J.; Topp, T.E.; Quigley, L. Depression and the willingness to expend cognitive and physical effort for rewards: A systematic review. *Clin. Psychol. Rev.* **2021**, *88*, 102065. [CrossRef]
47. Rzepa, E.; Fisk, J.; McCabe, C. Blunted neural response to anticipation, effort and consummation of reward and aversion in adolescents with depression symptomatology. *J. Psychopharmacol.* **2017**, *31*, 303–311. [CrossRef]
48. Stringaris, A.; Vidal-Ribas Belil, P.; Artiges, E.; Lemaitre, H.; Gollier-Briant, F.; Wolke, S.; Vulser, H.; Miranda, R.; Penttilä, J.; Struve, M.; et al. The brain's response to reward anticipation and depression in adolescence: Dimensionality, specificity, and longitudinal predictions in a community-based sample. *Am. J. Psychiatry* **2015**, *172*, 1215–1223. [CrossRef]
49. Brown, R.C.; Plener, P.L.; Groen, G.; Neff, D.; Bonenberger, M.; Abler, B. Differential neural processing of social exclusion and inclusion in adolescents with non-suicidal self-injury and young adults with borderline personality disorder. *Front. Psychiatry* **2017**, *8*, 267. [CrossRef] [PubMed]
50. Perini, I.; Gustafsson, P.A.; Hamilton, J.P.; Kämpe, R.; Mayo, L.M.; Heilig, M.; Zetterqvist, M. Brain-based classification of negative social bias in adolescents with nonsuicidal self-injury: Findings from simulated online social interaction. *eClinicalMedicine* **2019**, *13*, 81–90. [CrossRef] [PubMed]
51. Vega, D.; Ripollés, P.; Soto, À.; Torrubia, R.; Ribas, J.; Monreal, J.A.; Pascual, J.C.; Salvador, R.; Pomarol-Clotet, E.; Rodríguez-Fornells, A.; et al. Orbitofrontal overactivation in reward processing in borderline personality disorder: The role of non-suicidal self-injury. *Brain Imaging Behav.* **2018**, *12*, 217–228. [CrossRef]
52. Malejko, K.; Neff, D.; Brown, R.C.; Plener, P.L.; Bonenberger, M.; Abler, B.; Graf, H. Neural signatures of social inclusion in borderline personality disorder versus non-suicidal self-injury. *Brain Topogr.* **2019**, *32*, 753–761. [CrossRef]
53. Klonsky, E.D.; Muehlenkamp, J.J. Self-injury: A research review for the practitioner. *J. Clin. Psychol.* **2007**, *63*, 1045–1056. [CrossRef]
54. Wester, K.L.; Ivers, N.; Villalba, J.A.; Trepal, H.C.; Henson, R. The Relationship Between Nonsuicidal Self-Injury and Suicidal Ideation. *J. Couns. Dev.* **2016**, *94*, 3–12. [CrossRef]

55. Wood, S. Non-Suicidal Self-Injury: Prevalence and Correlates. Master's Thesis, Eastern Illinois University, Charleston, IL, USA, 2018. Available online: https://thekeep.eiu.edu/theses/3322 (accessed on 14 December 2025).
56. Ogden, J.; Bennett, A. Self-harm as a means to manage the public and private selves: A qualitative study of help seeking by adults. *Health Psychol. Open* **2015**, *2*, 2055102915605987. [CrossRef] [PubMed]
57. Chandler, A. Narrating the self-injured body. *Med. Humanit.* **2014**, *40*, 111–116. [CrossRef] [PubMed]
58. Fujiwara, J.; Usui, N.; Park, S.Q.; Williams, T.; Iijima, T.; Taira, M.; Tsutsui, K.-I.; Tobler, P.N. Value of freedom to choose encoded by the human brain. *J. Neurophysiol.* **2013**, *110*, 1915–1929. [CrossRef]
59. Leotti, L.A.; Delgado, M.R. The Inherent Reward of Choice. *Psychol. Sci.* **2011**, *22*, 1310–1318. [CrossRef]
60. Gyori, D.; Balazs, J. Nonsuicidal Self-Injury and Perfectionism: A Systematic Review. *Front. Psychiatry* **2021**, *12*, 691147. [CrossRef]
61. Gilbert, P.; McEwan, K.; Irons, C.; Bhundia, R.; Christie, R.; Broomhead, C.; Rockliff, H. Self-harm in a mixed clinical population: The roles of self-criticism, shame, and social rank. *Br. J. Clin. Psychol.* **2010**, *49*, 563–576. [CrossRef]
62. Glassman, L.H.; Weierich, M.R.; Hooley, J.M.; Deliberto, T.L.; Nock, M.K. Child maltreatment, non-suicidal self-injury, and the mediating role of self-criticism. *Behav. Res. Ther.* **2007**, *45*, 2483–2490. [CrossRef]
63. Dickson, J.M.; Moberly, N.J.; O'Dea, C.; Field, M. Goal Fluency, Pessimism and Disengagement in Depression. *PLoS ONE* **2016**, *11*, e0166259. [CrossRef] [PubMed]
64. Danchin, C.L.; MacLeod, A.K.; Tata, P. Painful engagement in deliberate self-harm: The role of conditional goal setting. *Behav. Res. Ther.* **2010**, *48*, 915–920. [CrossRef]
65. Heath, N.L.; Joly, M.; Carsley, D. Coping Self-Efficacy and Mindfulness in Non-Suicidal Self-Injury. *Mindfulness* **2016**, *7*, 1132–1141. [CrossRef]
66. Gamble, B.; Tippett, L.J.; Moreau, D.; Addis, D.R. The futures we want: How goal-directed imagination relates to mental health. *Clin. Psychol. Sci.* **2021**, *9*, 732–751. [CrossRef]
67. O'Connor, R.C.; Kirtley, O.J. The integrated motivational–volitional model of suicidal behaviour. *Philos. Trans. R. Soc. B: Biol. Sci.* **2018**, *373*, 20170268. [CrossRef]
68. Lockwood, J.; Daley, D.; Townsend, E.; Sayal, K. Impulsivity and self-harm in adolescence: A systematic review. *Eur. Child. Adolesc. Psychiatry* **2017**, *26*, 387–402. [CrossRef] [PubMed]
69. Watson, R.; Harvey, K.; McCabe, C.; Reynolds, S. Understanding anhedonia: A qualitative study exploring loss of interest and pleasure in adolescent depression. *Eur. Child. Adolesc. Psychiatry* **2020**, *29*, 489–499. [CrossRef]
70. Oettingen, G.; Mayer, D.; Portnow, S. Pleasure now, pain later: Positive fantasies about the future predict symptoms of depression. *Psychol. Sci.* **2016**, *27*, 345–353. [CrossRef] [PubMed]
71. Burnett Heyes, S.; Lau, J.Y.; Holmes, E.A. Mental imagery, emotion and psychopathology across child and adolescent development. *Dev. Cogn. Neurosci.* **2013**, *5*, 119–133. [CrossRef] [PubMed]
72. McMillan, R.; Kaufman, S.B.; Singer, J.L. Ode to positive constructive daydreaming. *Front. Psychol.* **2013**, *4*, 60812. [CrossRef]
73. D'Argembeau, A. The Role of Personal Goals in Future-Oriented Mental Time Travel. In *Seeing the Future: Theoretical Perspectives on Future-Oriented Mental Time Travel*; Oxford Academic Press: Oxford, UK, 2016; pp. 199–214.
74. Andrews-Hanna, J.R.; Kaiser, R.H.; Turner, A.E.; Reineberg, A.E.; Godinez, D.; Dimidjian, S.; Banich, M.T. A penny for your thoughts: Dimensions of self-generated thought content and relationships with individual differences in emotional wellbeing. *Front. Psychol.* **2013**, *4*, 900. [CrossRef]
75. Dickson, J.M.; Moberly, N.J. Reduced Specificity of Personal Goals and Explanations for Goal Attainment in Major Depression. *PLoS ONE* **2013**, *8*, e64512. [CrossRef]
76. Dewa, L.H.; Crandell, C.; Choong, E.; Jaques, J.; Bottle, A.; Kilkenny, C.; Gilbert, P.; McEwan, K.; Irons, C.; Bhundia, R.; et al. CCopeY: A Mixed-Methods Coproduced Study on the Mental Health Status and Coping Strategies of Young People During COVID-19 UK Lockdown. *J. Adolesc. Health* **2021**, *68*, 666–675. [CrossRef] [PubMed]
77. Palmier-Claus, J.; Duxbury, P.; Pratt, D.; Parker, S.; Sutton, C.; Lobban, F.; Moorhouse, J.; Kerry, E.; Russell, C.; Nyakutsikwa, B.; et al. A mental imagery intervention targeting suicidal ideation in university students: An assessor-blind, randomised controlled feasibility trial. *Behav. Res. Ther.* **2025**, *191*, 104780. [CrossRef] [PubMed]
78. Sosic-Vasic, Z.; Schaitz, C.; Mayer, B.; Maier, A.; Connemann, B.; Kroener, J. Treating emotion dysregulation in patients with borderline personality disorder using imagery rescripting: A two-session randomized controlled trial. *Behav. Res. Ther.* **2024**, *173*, 104454. [CrossRef] [PubMed]
79. Pile, V.; Smith, P.; Leamy, M.; Oliver, A.; Bennett, E.; Blackwell, S.E.; Meiser-Stedman, R.; Stringer, D.; Dunn, B.D.; Holmes, E.A.; et al. A feasibility randomised controlled trial of a brief early intervention for adolescent depression that targets emotional mental images and memory specificity (IMAGINE). *Behav. Res. Ther.* **2021**, *143*, 103876. [CrossRef]

healthcare

MDPI

Article

The Impact of Attempted Suicide on Young Adults: Learning from the Lived Experiences of UK Students in Further and Higher Education

Jude Smit *, Lisa Marzano and Erminia Colucci

Faculty of Science and Technology, Middlesex University, London NW4 4BT, UK; l.marzano@mdx.ac.uk (L.M.); e.colucci@mdx.ac.uk (E.C.)
* Correspondence: jsmit.research@gmail.com

Abstract

Background/Objectives: A need for suicide prevention and postvention strategies in Higher Education was identified in the United Kingdom and has more recently been addressed with policies that provide national guidance for organisations. However, a paucity of qualitative research related to the lived and living experiences of attempted suicide in young adults remains. The experts in attempted suicide are those who have experienced it and the objective of our study was to learn from these lived experiences, with a particular focus on 16–25-year-olds in Further and Higher Education. **Methods**: The research presented in this article was part of a nationwide study in the UK which included 21 semi-structured interviews with young adults who met these criteria on the impact of attempting suicide on a personal, interpersonal, and institutional level, and support service experiences and engagement. It aimed to answer two key questions: 1. What can we learn from the lived experiences of young adults who have attempted suicide? and 2. How can these findings be applied to better meet the needs of young adults experiencing suicidal thoughts/behaviour in Further and Higher Education? **Results**: Reflexive Thematic Analysis was used to analyse the data, and four main themes were identified: firstly, the impact on 'self', including emotional and psychological impact; secondly, 'others', revealing the impact of and on relational factors, stigma, and judgement; thirdly, 'systemic', which highlighted support service experiences and barriers to accessing and engaging with possible support, and, fourthly, 'what helps or could help' on a relational, educational, and institutional level. **Conclusions**: The findings from this study generate new insights into this under-explored and stigmatised area and point to key barriers to support and gaps in service provision. Attempting suicide is one of the highest risk factors for a death by suicide and this study highlights the need for additional policy and support guidance for attempted suicide in Further and Higher Education.

Keywords: suicide; suicide attempt; student; education; Further Education; Higher Education; lived experience; mental health; stigma

1. Introduction and Context

Much has been written about suicide and suicidal behaviour in post-16 education [1–3], but with less focus on lived and living experiences, particularly of people who have attempted suicide. Although models and guidance for student suicide prevention within Further and Higher Education exist [4,5] and university guidance, such as 'Suicide-Safer

Universities' [6] and 'Responding to Suicide: Advice for Universities' [7], has been created, engagement with and access to support continue to be the greatest barriers [8]. "Suicide is a whispered word" [9] and its taboo nature create internal and external barriers that silence it. Although the lived experiences of suicide are unique to the individual, the social determinants of suicide [10] need to considered.

Existing literature identifies the impact of stigma on interpersonal relationships and potential help-seeking as a key contributing factor [11,12], with transitions between organisations heightening loneliness and social isolation amongst new peers, staff and, structures [13]. Such loneliness is, in turn, a known risk factor and can increase the risk of suicide following an attempt [14,15]. For example, research has pointed to the association between social identity [16] and a lack of connectedness [17] or sense of belonging, including institutional belonging and suicide attempts, and highlighted the importance of social support [14].

Self-stigma and self-perceived social failure [14,18] can manifest as an individual's internalising of externally perceived stigma and, consequently, an erosion of self-belief, leading to self-discrimination [12]. The prevalence of self-stigma also challenges self-compassion [19–21] and a lack of self-efficacy can be a factor in not seeking help. Low, or lack of, self-efficacy and the impact of trauma-related shame [18,22], bullying and victimisation [23] have been found to lead to increased emotional distress and add to feelings of hopelessness. The impact of pressures and expectation on academic functioning and performance are recognised, leading to increased anxiety and stress associated with perceived academic achievement [24–26].

Public and personal stigma [27] have also been linked to barriers to the use of mental health services within colleges and universities [27]. Some studies have found that young adults thinking about suicide are less likely to confide in mental health professionals [16,28] and that discrimination, stigma associated with mental illness, social identity, and negative social stereotypes [16,29] can lead to the fear of friends or family finding out [30]. This creates further barriers to potential help-seeking [16]. Interpersonal interactions that are perceived to be negative, critical, or rejecting are also found to increase the risk [21]. Students with disclosed or diagnosed mental health challenges are twice as likely to leave university without completing their degree [24].

Suicide remains often pathologised [31]. Defining suicide in this way is, however, reductive and reinforces prejudice, stigma, and self-stigma by not accounting for the contributory social, cultural, and political factors [32,33]. Suicidal thoughts, feelings, and behaviours can be experienced by anyone for a variety of reasons at any point in their life.

By focusing on lived and living experiences, we can gain unique insights into the impact on a person's sense of self, sense of others, and ways of being in the world, as well as identifying what has helped someone to stay alive [34]. The aim of this study was, therefore, to explore what we can learn from the lived experiences of attempted suicide in young adults, with a particular focus on their experiences of, and engagement with, Further and Higher Education. Both lived and living experience are referred to in this article: the former refers to those for whom the experiences reported are in the past and the latter those living with suicidal thoughts, feelings, and behaviours in their present.

2. Methods

2.1. Design and Sample

As part of a wider UK-based mixed-methods study of young people's experiences of attempting suicide whilst in Further or Highter Education [35], we conducted semi-structured interviews with 21 students with lived and living experiences of suicidality.

Participants ranged from 16 to 25 years old and included people with neurodivergence, diverse genders, ethnic backgrounds, and cultural beliefs. To protect anonymity, an aggregate of participant characteristics has been included as Table 1.

Table 1. Participant characteristics.

Area of the UK	Ages	Gender	Further/Higher Education	Ethnicity
London: 3 Southeast: 9 Southwest: 1 East Midlands: 2 Yorkshire and the Humber: 1 Scotland: 4 Northern Ireland: 1	16–18: 6 19–21: 4 21–23: 6 23–25: 5 *(N.B. 1 person included turned 26 by the time of interview.)*	Female: 13 Male: 3 Non-binary: 3 Transgender Male: 2	FE: 6 HE: 15	White British: 16 Any other white background: 2 Any other Asian background: 1 East Slavic: 1 Prefer not to answer: 1

They were recruited via a national survey [35], which was promoted on social media and via organisations and individuals that supported the study (e.g., through relevant special interest groups and charities, such as MQ Mental Health Research). The survey was designed to gather experiences of attempted suicide amongst young adults at colleges and universities, and included an invitation to take part in a follow-up interview. In compliance with university ethics regulation, we discouraged participation from those who had made a suicide attempt within the previous 6 months. In 3 cases, participants who had made more recent attempts still wanted to be involved and asked if they could be contacted when 6 months had passed. This was honoured, as it felt important to be able to include everyone that wanted to participate. The interviews took place between January 2020 and May 2021. The study was non-selective, providing participants met the study criteria: aged between 16–25, in Further or Higher Education, and had attempted suicide. Everyone who came forward was included in the study.

2.2. Materials and Procedure

A semi-structured interview schedule (Supplementary File S2) was developed to create a framework and structure to the interviews. This included questions about how many suicide attempts they had made and how many of these they had disclosed to their college and/or university. They were also asked about their experiences of transition between school and college/college and university and any challenges experienced in college/university. Participants were also asked about support and suicide attempts, how suicide attempts impacted their college/university experiences and if support was available, what was helpful, what was unhelpful, or what could have been helpful. Questions included a focus on lived experiences and the impact on oneself, what participants would like others to know about attempted suicide, and any myths they would like to challenge or dispel.

Participant wellbeing was at the heart of the interviewing and wider research process. For example, participants were provided with extensive information in advance about the study, their voluntary involvement, and data use. To give time and space to hear what participants wanted to share, no time limit was set and interviews lasted between 40 min and 2 h. For some, this was the first time they had spoken about their experiences. Containment and safeguarding remained a priority. Time was given at the start to ask any questions and to debrief at the end of the interview, as well as consideration given to any potential need for ongoing psychological support. All interviews were conducted by JS, who is a psychotherapist/integrative arts psychotherapist and had access to clinical

supervision. Consolidated criteria for reporting qualitative studies (COREQ) can be found in the online appendix (see Supplementary File S1) [36].

2.3. Ethics

This study was approved by the Middlesex University Psychology Research Ethics Committee (ref. 7390). All research materials and procedures were developed in consultation with a participatory research group (PRG), which included people with lived experiences, Samaritans, a mental health and education visual media correspondent, academic experts, and senior college/university welfare and safeguarding staff. Participants gave written informed consent, with the option to withdraw from the study within 8 weeks of participation (which no participant took up). Data protection and protecting identity were carefully considered. Any identifiable material was removed or redacted to ensure anonymity.

2.4. Data Analysis

The interviews generated a large amount of data. Reflexive Thematic Analysis [37] was used, drawing on a critical realist perspective [38,39]. This provides a robust and respectful approach to the complexity of lived experiences, taking account of the individual's unique experience, whilst deepening our understanding of the underlying contributory causal factors. It enabled a reflexive process where semantic and latent coding [37] was possible and supported an inductive approach, looking for conscious and unconscious communication to capture both explicit and implicit meaning. Reflexive TA takes account of the researcher's role in the process of analysis and examines how potential subjectivity could influence emergent patterns. Researcher bias was considered, especially as the lead researcher had a long working history with people experiencing trauma and suicidality. Keeping track of coding and ensuring consistency and rigour was paramount. Although frequency of codes is not a specific feature of reflexive TA per se, it was helpful to keep track of particular codes that recurred. To ensure robustness and maintain internal integrity of the analytic process, MAXQDA 2022 [40] software was used.

The structure of Reflexive Thematic Analysis (TA) was followed [37]: 1. familiarising yourself with the data, 2. generating initial codes, 3. generating initial themes, 4. reviewing themes, 5. defining and naming the themes, and 6. writing up. All interviews were transcribed and read and re-read as a whole, and any initial codes and overarching ideas and themes noted. Next, 10 interviews were selected across timeframes, age, level of study, gender, intersections, and length of interview. These were coded and recoded inductively in-depth. This generated a large number of codes which were then reviewed, and emergent themes identified. Codes were further refined to detect overlap or similarity. Where appropriate, codes were merged. The remainder of the data were then analysed and codes tracked, looking out for any new coding or possible themes. Finally, all data were reviewed again, and themes and sub-themes were reviewed, defined, and named.

Once this process was complete, data were further interrogated, drawing on Corbin and Strauss's grounded theory coding paradigm [41]. This was adapted to provide additional structure, as a framework to help organise the themes and how to best present these to form a coherent narrative and draw most meaningful conclusions.

Saturation in qualitative research is a recently debated concept [42,43]; however, data were analysed and re-analysed until no new themes emerged. Data codes and themes were reviewed by the research supervisors (LM and EC) and a specialist MAXQDA coach.

3. Findings

We identified four key overarching themes in the interview data: self; others/relational; systemic, including education, health, and barriers; and what helps or could help (Figure 1).

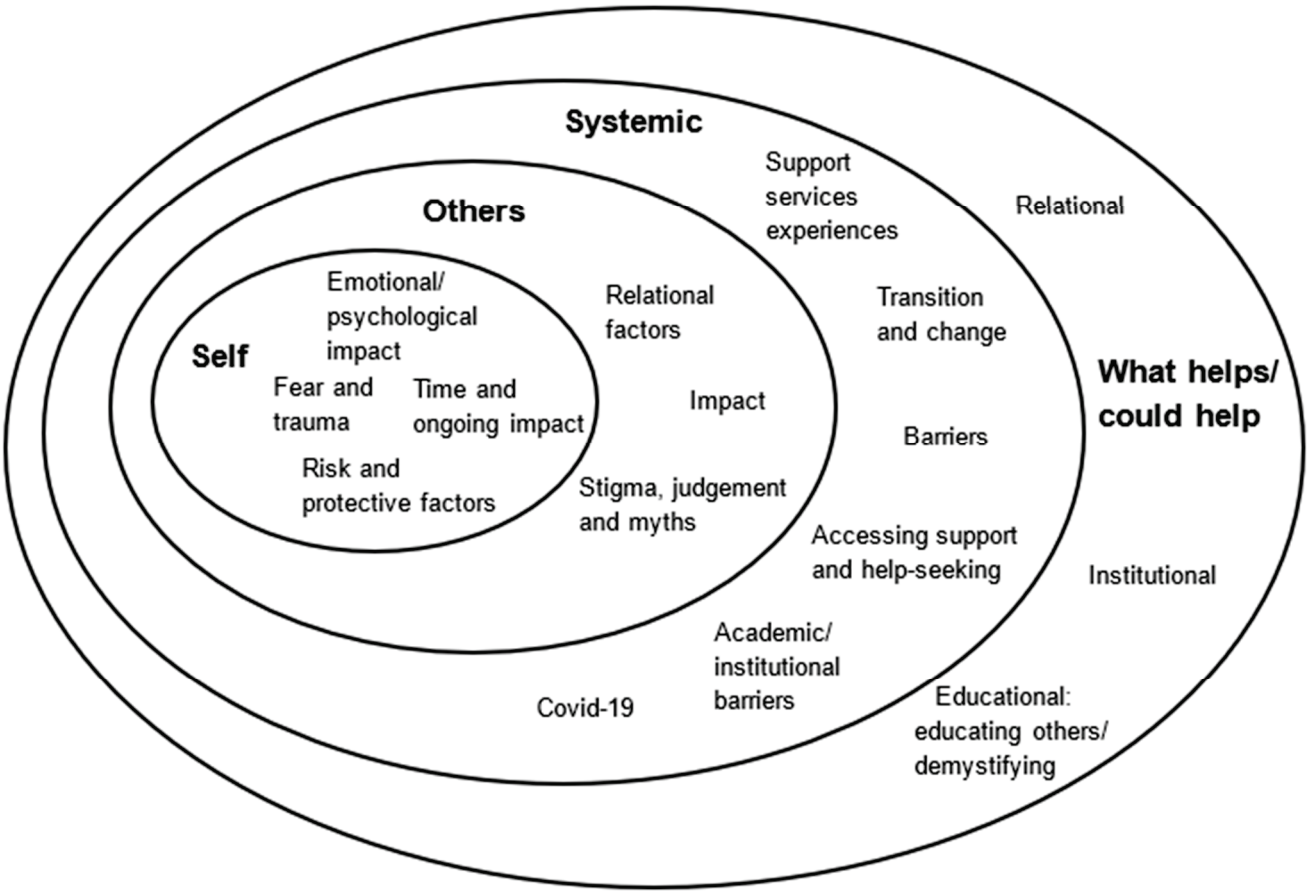

Figure 1. Impact of and on attempted suicide in Further and Higher Education students.

Participants' accounts showed the emotional and psychological effects of attempted suicide, and factors contributing to it, on a person's sense of self and ways of being. The diagram (Figure 1) shows how the overarching themes of self, others/relational, systemic, and insights into what helps or could help all intersect, with commonalities that shall be discussed in more detail.

We will first discuss the impact of and on Further and Higher Education, followed by further contributing personal and interpersonal factors.

3.1. Support Services Experiences and Barriers

Initially, the plan was to code support service experiences for each educational sector, but, as the participants were not evenly split across sectors, this was not possible. Consequently, systemic issues have been reviewed more broadly, but factors specific to a particular sector, such as experiences of transitions, were identified.

As the interviews progressed, it became clear that this broader overview of support revealed patterns that may not have emerged otherwise. Participants relayed negative and positive experiences within academic and medical systems and how both impacted each other, including barriers and a lack of support availability or provision. For many, previous experiences of systemic stigma and judgement originated much earlier, at school and in child and adolescent services. The impact and implicit fear of these early experiences and fear of negative consequences transferred to organisations later on and inhibited disclosure.

Barriers often pre-dated the time at college and/or university, with many negative school experiences shared. A participant reflected:

> "*I don't feel ashamed about it anymore because I think it's a reflection of how I felt at the time and how I was being handled at the time by my school.*"
>
> (R0015, female, H.E.)

Although the study was not related to school or school age, its recurrence across all interviews is relevant as these experiences became future academic and systemic barriers. Examples given were oversharing without consent, not being able to go to school, information not being responded to, and feeling marginalised, unmet, misunderstood, shamed, and not being believed about the severity of experience. These manifested in ongoing and future educational barriers and internalised self-stigma. A participant commented:

> "*Just because someone hasn't succeeded at completing suicide doesn't mean that that wasn't their goal, that someone wasn't in a really dark place.*"
>
> (R0020, female, H.E.)

Systemically, participants noted a lack of medical services, support availability and gaps in service provision across all sectors. This included a lack of immediate support, or joined-up, long-term support and parity between physical and mental health. They noted limited choice of support options and capacity, with long waiting lists. Participants described feeling deprioritised and stuck in a system, being moved around services or being referred on when considered too high-risk or felt to be "too serious" once they mentioned suicidal thoughts. Services and support were not easily accessible and what was offered was limited or cut off abruptly. Support was generalised and not ongoing or not targeted at suicidality:

> "*It wasn't very helpful because I think they were just sort of trying to do a one size fits all approach.*"
>
> (R0016, female, H.E.)

Some participants had made numerous attempts at help-seeking, but none was available at the time. A participant recalled:

> "*She said that with waiting lists and my severity that it was unlikely that it would be anytime soon, and that leaves you thinking… what other solution do I have and that is suicide, which is what I turn to.*"
>
> (R0013, female, F.E.)

This eventually stopped another participant from reaching out, "*because at one point I'd had a mental health assessment nine times in a month and each time I got sent away, said go home, and that was me asking for help*." (R0005, male, H.E.)

3.2. Transitional Barriers

Participants largely felt unprepared for change and transition and experienced anxiety, nervousness, and apprehension about change, and fear of not coping. Participants described particular difficulty at the start of college and/or university and noted an increase in academic demands across all transitions as well as a need to get used to academic demands over time. There was a lack of information about support ahead of the transition and subsequent support with the transition, and a feeling that more could have been done. One participant recalled, "*I arrived there and there was so much they could have done to support me*" (R0014, female, H.E.). Participants expressed a need to raise awareness about transitions, so that people can be more informed and mentally prepared. Another participant reflected on the implications of this:

> "*I didn't mentally prepare, and so I think that was definitely a factor because I didn't give myself the time to accept that I will be overwhelmed and that I was scared about it, I just pushed that down.*"
>
> (R0018, non-binary, F.E.)

Participants' attempts at support-seeking were evident and raised issues around the accessibility of information and thresholds to services, knowing when to seek support, not meeting the threshold for mental health support, or a need for diagnosis to access support being presented as barriers. Not knowing what support was available or who to contact led to feelings of disillusionment and defeat.

Support in academic establishments was described as having a limited focus on mental health support, with educational support services advertised as disability support, not mental health support. A lack of signposting, information sharing, and inaccessible language were often experienced as barriers and equality issues were raised, as expressed by this participant:

> "*They need to be signposting services, they need to be making sure that there are services there.*"
>
> (R0014, female, F.E.)

Some highlighted the social challenges with transitions and expressed feeling lonely and needing social contact, adjusting to living with new people, not able being to settle, and the ongoing challenge of being in university: "*university is hard*."

Participants identified positive experiences that broke down some of these barriers. They appreciated supportive tutors and teacher sensitivity, a collaborative approach, with targeted academic support and the proactive sharing of resources and helping to manage expectations.

3.3. Relational Barriers

Overarchingly, relational aspects appeared to affect participants the most and challenges included feelings of obligation, peer-pressure, people-pleasing, and sacrificing the self. Power dynamics and negative responses from others when help-seeking at points of crisis were at times described as catastrophic. Needing to justify oneself and "*not being understood and not being… taken seriously*" created barriers (e.g., "*I won't go to my mental health team or my crisis team now because…they tell me that it's not a crisis and if I was serious, I would just go and do something, I won't go to them*" (R0007, female, H.E.). This also applied to going to hospital at times of crisis.

Relational factors presented as barriers, both academically and institutionally. Participants described feeling shut down by staff and expressed mixed experiences of educational responses post-attempt. They recalled the need for justification to obtain university support, intrusive questioning, and having to share information for university admin purposes and the challenging process to obtain academic extenuation; as indicated by one participant, it felt like "*an interrogation almost like why do you need the extension*" (R0011, female, H.E.).

The importance of the relationship and relational elements affected support. Building trust takes time and support needed to come from someone you know or can get to know. To keep having to tell one's story due to a lack of consistent support created barriers and reinforced attachment challenges. A participant commented, "*even though there was other support, I kind of needed someone which I had a really good relationship with, and I didn't feel I had that specifically*" (R0010, female, H.E.). The inconsistency and changeability of support and the person who was seen reinforced feelings of abandonment and fear that support be withdrawn or a support person would leave.

Some participants reflected that disclosures were not always followed up, or they were not checked up on after they had shared that they were experiencing difficulties/challenges. Others described going back after an attempt and staff being ill-equipped to navigate these conversations, resulting in restrictions on courses and suggestions to leave the course; for example, "*with tutors trying to get me to drop out, I feel like I'd have to become like this perfect student. . .I feel like I'm not allowed to struggle*" (R0012, female, H.E.). Additionally, disclosures were reported to impact university accommodation and, for some, resulted in being asked to leave. A participant explained:

> "*It's basically just the fact after one mention of suicide they decided to chuck me out and they wanted me off campus as well, the university wanted me out of the halls of residence because I was too risky.*"
>
> (R0005, male, H.E.)

Barriers to accessing support were closely linked to barriers to sharing and help-seeking. Disclosure felt complex, with difficulty speaking about the attempt and fear of consequences from opening up to student services. Some expressed unease at not knowing what had been shared about them with an educational establishment. Participants reflected on fears of parents or other people finding out, or the consequences of telling, such as choice being removed. Participants felt disempowered when people were told about their attempt(s) without their consent, or if they were forced to tell or disclose because of circumstance.

Expectations from support providers often added pressure to share more than participants felt comfortable. A power imbalance presented itself and participants felt pressured to talk about attempts, describing this as intrusive and feeling under surveillance. Some conveyed the negative impact of others taking control and gave examples of parents being told about their attempts without their choice or consent. A participant reflected:

> "*I remember being careful about what I said in terms of suicide because I didn't want there to be consequences.*"
>
> (R0015, female, H.E.)

Detachment arose from a lack of communication and connection to people and to the wider world, such as a lack of family or home support and community. Participants expressed a want and need for help and de-escalation; they were willing to ask for support but, in many cases, found the barriers too challenging. They identified a lack of respect for suicidal people, space to talk, and validation, as well as preventative measures post-attempt and support or specific support service for survivors of suicide attempts.

Missed opportunities for intervention came up repeatedly and were the most challenging to see emerging across the data. Although this varied from person to person, it was clear that there was an evident and apparent timeframe where intervention could have been possible. A participant observed, "*I was actually warning people six months before it happened. . .saying I'm going to crash, this is going to end badly, I'm going to crash!*" to both their school and a psychologist (R0008, transgender male, F.E.).

Some participants were aware of college/university support, but they were not accessing or engaging with services and described difficulty communicating. The immediacy of support availability was evident and there was a need for earlier intervention that was targeted and accessible. For some, this meant in-person rather than phone support, and, for others, text-based support. They described a need for agency, empowerment, and independence and reinforced the need to be seen as an individual and to be mindful of different experiences. They wished to take their own initiatives and have a choice in telling people about their attempt, as well as a say in support options and action planning.

Some participants described positive experiences of reaching out for support and a change in perspective, feeling more connected to support post-attempt. Service and organisational approaches deemed helpful offered proactive, solution-focused, directed support, where participants felt prioritised, respected, and validated with dignity. A participant explained this:

> "*Targeting the problem from many different aspects, rather than just kind of what just happened and how do we get over that.*"
>
> (R0011, female, H.E.)

It took a long time to find the 'right' support and interviewees said that what was most helpful was regular, ongoing support, particularly post-attempt. Again, human, interpersonal qualities were most important, such as acknowledgment, understanding, and being cared about. Participants expressed a need for trust, compassion, kindness, and respect, including respect for personal space. Staying out of hospital was a motivator.

When considering the relational impact, what particularly stood out was the positive impact of one specific person alongside them at the time, for some, still remembered years later. The human, relational qualities were most impactful. A participant remembered someone's kindness, care, and compassion:

> "*It's not her role to support students in that way but she did, and I found that more helpful than any other support I got.*"
>
> (R0011, female, H.E.)

Additionally, the difficulty speaking about the attempt or attempts to others, but the willingness and openness to share in the interviews themselves were notable. Some spoke about their lived experiences for the first time. Participants fed back positively about being able to speak freely and openly in the interview and to share as much or as little as they chose to, without pressure or expectation:

> "*It doesn't feel as uncomfortable because I know I'm just answering a question, we don't have to go into depth about it. . .it's very much like I'm just explaining it as it is and so it feels a bit more, I guess, controlled.*"
>
> (R0018, non-binary, F.E.)

3.4. Stigma/Judgement/Myths

Participants were asked to comment on any myths or perceptions they wished to challenge. Negative assumptions and negative reinforcement were prevalent and early experiences starting at school had developed into withdrawal, self-stigma, and isolation. Participants remarked on the negative impact of biased media representation and public perception, people's judgement, and misunderstanding about suicidal behaviour as a way of communicating distress, with comments such as "*attention seeking*", "*cry for help*", and "*not being serious*" about the attempt if they survived it. One participant clarified:

> "*If you think to yourself, oh that person just wants attention, oh my God, how bad is that, that that person is hurting so much that the only way they felt like they could reach out for help was putting their own life at risk. . .we all want attention.*"
>
> (R0010, female, H.E.)

The impact of misconception was discussed and words such as "*selfish*" and "*weak*" were challenged.

The taboo nature of suicidality and fear of judgement and stigma led to hiding or having minimised the attempt. Participants professed that many people experience suicidal thoughts, feelings, and behaviours, but few speak about it. Stigma that derives from myths,

misinformation, misconception, and judgement leads to self-stigma and internalised shame that silences. A participant summarised:

> "*I think I had a lot of shame to do with suicide and self-harm, just from the way that people had responded to it*."
>
> (R0015, female, H.E.)

Stigma and judgement can make an attempted suicide a dehumanising experience at a time when someone is already at their lowest point and contribute to further feelings of hopelessness and defeat. Participants emphasised social injustice and being reduced to statistics, reinforcing the dehumanising impact of post-attempt experiences. They also noted that a risk-averse narrative and unhelpful platitudes were alienating, stating "*I think the stigma only harms*". Unconscious bias and stigma included stereotypes about increased suicide in people with protected characteristics.

Participants described feeling 'different' to others and not fitting in. They cited negative experiences of the social environment and spoke of global inequality. What is clear from the data analysis is the major impact a person's response to someone who has attempted suicide can have. One participant summarised:

> "*For me it's never really been the attempt itself, it's been the reaction from other people that's been the biggest deal out of any of it*."
>
> (R0008, transgender male, F.E.)

Assumption and myths were seen as presenting significant barriers to speaking about suicide. In the words of an interviewee:

> "*Once society has changed their view on suicide, and then more people will come out and it doesn't have to be like. . .even me. . .I'm too scared of their reaction. It shouldn't be that way at all*."
>
> (R0005, male, H.E.)

A lack of understanding and awareness was expressed and attributed to inexperience within medical and mental health teams and insufficient training for medical staff or tutors. Negative assumptions/comments and advice reinforced feeling of shame. One participant explained:

> "*I still feel quite a lot of shame about it, like I don't tell people when I get to that level of low*."
>
> (R0015, female, H.E.)

It was difficult to hear how isolated and alone participants had felt and the barriers that stigma and judgement created, making it feel impossible to reach out: "*people that are considering suicide do not have the capacity to reach out and get help*" (R0013, female, H.E.). At this point, "*they need people to reach out to them*" and, in some cases, it took an attempt to realise that people cared.

In this context, suicide prevention campaigns were deemed largely ineffective. Many were said to be focused on encouraging people to reach out for help. Most participants voiced that, particularly, in challenging times, this could be the hardest thing to do:

> "*One of the biggest things for me, and I know for a lot of other people who go through things like this, is reaching out is the hardest part*."
>
> (R0015, female, H.E.)

The need to demedicalise suicide was clear, with misconceptions about who can become suicidal questioned: "*it can happen to anyone*" (R0013, female, H.E.). Participants made

the distinction between thoughts, feelings, and actions and they challenged the assumption that having future plans in life is an indicator that someone is not actively suicidal.

3.5. Fear and Trauma

Fear of stigma and judgement was a significant barrier to speaking about challenges faced and accessing support, both at the time of and after their attempt. Participants described feeling threatened, fear of failure, fear of getting worse, and getting things wrong. Examples of abuse and the impact of early childhood experiences affected the person's sense of self/other/world, including unresolved trauma and not being believed about traumatic events. Some identified a specific event shortly before an attempt and also post-attempt trauma triggers, such as the sound of sirens, evidencing both the impact of traumatic events and the trauma and circumstances of the attempt itself. These included mixed responses to and from ambulance, police, and hospital staff interventions, and affected a person's way of seeing oneself and others and future help-seeking.

3.6. Emotional/Psychological Impact

Participants discussed the impact of their attempt(s) on their sense of self, and ways of being and relating to others, society, and the world. This included the challenge of being oneself and needing to put on a mask. As one participant explained:

> "*With my friends I was always the jokey guy. . .when I was at home, it was almost like flipping a coin. . .just you know the same coin different face.*"
>
> (R0021, male, F.E.)

Covering up and masking led to a presented self [44], a silent struggle, where the extent of despair was underplayed. Another participant noted "*I kind of tried to smile my sorrows away*".

The internalised message to '*stay strong*' and having to keep going whilst experiencing despair affected functioning and enhanced feelings of perfectionism. This split fuelled a negative cycle of trying harder and further masking that increased hopelessness. As one participant expressed, "*it just kind of went into more kind of hopelessness*" (R0020, female, HE). This resulted in a greater need to withdraw, hide, and isolate from others. Participants identified shame, self-blame, disappointment in themselves, and having to live, or not living up to, expectations. An example of the impact was shared:

> "*Often I know at least personally I wouldn't want to speak to someone about that because I would feel probably guilty or ashamed.*"
>
> (R0020, female, H.E.)

Others expressed guilt, grief, frustration, and anger, and/or described feeling selfish and unworthy of support, like a burden, like they were no longer needed, and like they had a negative impact on the world, or that they did not belong:

> "*I think I've always felt like I was a mistake in the world or like an anomaly.*"
>
> (R0018, non-binary, F.E.)

Participants felt misunderstood and described the impact on their self-worth and self-value, a loss of identity, and loss of themselves. Some felt defined by their attempt(s) and that suicidality was a part of themselves:

> "*I think a lot of people kind of hold onto that pain and really internalise and fear letting it go, as if they'll be letting go an important part of themself, and you know that pain is something that if people have gone through then it's traumatic.*"
>
> (R0016, non-binary, F.E.)

The unspoken and internalised invisibility of hurt, emotional weight, and pain was clear in many accounts. For some, this manifested in feelings of resignation and defeat. Functioning day to day whilst masking was hard and they described low mood and loss of interest, feeling lonely, isolated. A participant conveyed the sense of inevitability expressed by many and being at a 'dead end': "*I was so sad, and I was so empty*" (R0018, non-binary, F.E.). The extent of the despair affected self-care and self-compassion. They felt disempowered, lacking agency, rejected, and let down. Feelings of abandonment and ongoing hardship eventually led to disconnection, and detachment from self, others, and the world. Another participant described the tiredness of life [45] and stated, "*I was just kind of done with doing the same thing every day*" (R0011, female, H.E.).

The preoccupation and persistence in suicidal thoughts overwhelmed and participants felt tired, trapped, "*spiralling down*", with no escape and "*not being able to see into the future*". The extent of hopelessness and helplessness was clear and there was a need for a way out. One participant used a powerful metaphor to illustrate this point:

> "*Say they're trapped in a box and they're kind of saying, OK, well you know suicide's this trap door.*"
>
> (R0020, female, H.E.)

Some participants stated that they had wanted to die, but others felt relief when they realised that they had not died. Participants discussed not wanting to act on thoughts. Suicide is "*not always wanting to die*" (R0009, female, F.E.), but a response to total despair and hopelessness. Some expressed needing to hit rock bottom before being able to find a way forward. They described not feeling able to be alone or to go to sleep, unable to trust or keep themselves safe ("*It's really, really difficult to pause between that feeling and that action*" R0018, non-binary, F.E.), but, at the same time, unable to reach out and needing to fight and hold onto some hope that support was available.

Many participants described numbness at the time of attempting ("*It's like I felt nothing, I was just completely empty. And I think that's almost always the same feeling*" (R0018, non-binary, F.E.)), or once they realised that they had lived beyond the attempt:

> "*I think I just didn't really feel anything. . .it wasn't like a sense of relief, it wasn't a sense of regret, it was just absolutely nothing.*"
>
> (R0016, non-binary, H.E.)

Some participants recalled feeling that a failed attempt meant that suicide was no longer an option ("*It's the last option, so what do you do when the last option's taken away, you literally feel like you have nothing left*" R0010, female, H.E.). This, in turn, reinforced negative self-belief, with punitive statements such as "*I can't even get that right*," whereas, for others, the lasting effect of a failed attempt was a driver for future attempts, for example:

> "*My first attempt was like unfinished business, almost like a ghost I would say, like oh why didn't you do this, you should have done it, you're not good enough and so on.*"
>
> (R0021, male, F.E.)

Many participants described feeling changed after the attempt and difficulty adjusting to life post-attempt, like a different person. In contrast to feeling defined by the suicide attempt, some participants described it with ambivalence as "*just something that happened. . .an event*."

3.7. Ongoing Impact

Codes related to time, transience, and the long-term, lasting effects post-attempt highlighted the ongoing impact and complexity of suicide. Participants explained that the feelings are changeable and can fade over time, but a fear of the feelings returning remains.

Participants were clear that an attempt is not an isolated event and that there are multiple contributing factors to suicide. A participant reflected:

> "*I never expected it to get that bad I always believed I'd get through it somehow, because you know I've felt suicidal multiple times in my life and I've managed to dig myself out of that big hole and keep going.*"
>
> (R0019, female, H.E.)

Nuanced differences in experience were identified, such as fluctuations in the intensity of suicidal feelings, levels of intent, and capacity to be proactive. These were largely impacted by relational factors.

Suicide was described in several ways, as a coping mechanism over time, as a way out/escape, as an impulsive act, or as a carefully planned process. As one participant explained:

> "*My attempts aren't necessarily impulsive, they tend to have months of build-up and then they kind of happen. . .kind of opportunistically but very planned. . .it's not like I have an argument and I attempt.*"
>
> (R0008, transgender male, F.E.)

Sometimes, life felt like an ongoing battle and the attempt was the result of utter hopelessness. Some were unable to identify a specific trigger and expressed that, in that moment, suicide was not rational, as they were not able to think. Others described it as a carefully thought-out process:

> "*It was the weighing up of pros and cons, which for me felt very rational, rather than the emotional kind of feelings you associate with suicide.*"
>
> (R0013, female, F.E.)

Other participants described living alongside suicidal thoughts, always there in some form as a part of someone's life:

> "*It's so weird how you just like move on from that. But I think a part of me never really does. And I think there is a void from each time, and I do try to fill it with things. . .but it doesn't work.*"
>
> (R0018, non-binary, F.E.)

Adjusting to life post-attempt included conflicted feelings of regret, wishing it had worked, or a wish to attempt again. Some experienced this as an enduring, ongoing challenge:

> "*A lot of the time people get through a suicide attempt and they haven't had this epiphany, they feel the same, and being told by everyone they should feel grateful when it's like, honestly I've never felt less grateful. . .It's the last option, so what do you do when the last option's taken away, you literally feel like you have nothing left.*"
>
> (R0010, female, H.E.)

The length of one's recovery time was a common theme and the challenge of needing to plan life post-attempt was clear. The month directly after and up to six months following an attempt were described as the hardest:

> "*It's not just the crisis point that's difficult, it's kind of the months after it that are most difficulty, at least in my experience.*"
>
> (R0011, female, H.E.)

Not having expected to live beyond a death date compounded uncertainty about the future and was fuelled by 'what ifs' and 'what comes next'. The unique nature of lived experience was noted, and the impact of living beyond a death date. The participant explained:

> "*It felt like I had to plan my life over again, because in my head I wasn't going to be here after that set date. . .it's almost like you've got a life that I didn't expect to have.*"
>
> (R0011, female, H.E.)

Some participants spoke of the complexities related to not knowing, or having, a place in the world, or not having found one's purpose yet. The data reflected endurance and patience, waiting for the future to take shape.

Changes in feelings post-attempt were identified. For some participants, an attempt was a turning point. They shared that time was helpful and made a positive difference, providing a capacity for reflection. They noticed a change in perspective and perception about staying in the world, focusing on life ahead, or life moving on or moving forward. In the words of one participant:

> "*I'm glad that I got help now and that I survived it, because even though my life is not perfect, far from it. . .I'm trying to do a lot more with my life now. . .I wouldn't have got where I was now.*"
>
> (R0012, female, H.E.)

3.8. What Helps/Could Help

Participants were asked to identify what was helpful at the time and for any suggestions as to what could be, or could have been, helpful based on their past experiences. A participant summarised what many expressed, that, with more support, most of the attempts could have been preventable:

> "*I feel like a lot of this could have been preventative had it have been from like the earliest start as possible.*"
>
> (R0006, female, H.E.)

The need for support, particularly for ongoing support post-attempt, was evident. Consistency and a proactive approach, being reached out to, and the importance and impact of a specific person were especially noteworthy. The importance of systemic support and student services were recognised, both academic as well as pastoral support. Meeting individual needs, accessibility, and easy access to resources were key:

> "*It would save so much time and effort and money and service space if they were more proactive from the beginning. . .they need to be engaging robust support, they need to be signposting services, they need to be making sure that there is services there, and that there are reasonable waiting times.*"
>
> (R0014, female, F.E.)

Participants understood the pressure on services but stressed the need for "*quicker referrals*", quicker response times, and proactively being reached out to. Transparency from the start and highlighting which services were available would help with this.

Preparing students in advance with transition support across organisations could be beneficial; a participant recalled that "*I think just being more educated on things is always the way forwards*" (R0017, male, H.E.). They needed to see and get to know the person within the institution offering support.

Again, the taboo nature of suicide was raised, and the need for safer spaces and a support network. A wish to be reached out to and for people to understand, for someone to be alongside them who was respectful, validating and reassuring, open-minded, and non-judgemental, and who could actively advocate for and engage in joining up support.

Human connection, interaction, and the physical presence of others fostered a sense of belonging and community. The availability of support was vital. Ideally, this would come from someone known, such as friends, partners, and parents, or professionals who were

consistent and whose support was ongoing. Someone proactively asking about the attempt and looking beyond the surface presentation encouraged disclosure, openness about the experience, and reduced suicidality. The value of listening, and feeling seen and heard were stressed, as described by one participant:

> "*Listen to people, rather than going off your own assumptions of what's the right thing to do, ask them. . .listen to them I think is the most important thing to do.*"
>
> (R0015, female, H.E.)

Addressing many of the issues raised earlier in schools would mitigate some of the challenges experienced later.

Joined-up support, with a relational, collaborative, flexible, co-created, holistic approach felt empowering and supported a sense of agency. Taking account of individual needs where organisations could put in place what students themselves considered most helpful, to "*tailor it to the individual. . .you can't have dignity without person-centred care.*" (R0010, female, H.E.). With consent, carefully considered cross-college/university sharing of information with staff could be worthwhile. This would avoid the potential challenges in communication for both staff and the student, especially around administrative matters such as absences and late submissions. Having a GP on the campus was found to be helpful.

A wish for more specific, targeted support for survivors of attempted suicide was clearly communicated:

> "*There is nothing for survivors afterwards, after the attempt, or to prevent that thought process from ongoing to going from between I feel like a coward to I need to try that again, which really makes me angry.*"
>
> (R0006, female, H.E.)

3.9. Educating Others and Demystifying

Current education and awareness around suicide prevention were perceived as positivist, tokenistic, and not integrated. Participants stressed the importance of knowledge about mental health and the need for more trained professionals within institutions ("*although her compassion you know was there, she probably could have done with some training*" (R0006, female, H.E.)) Specific education and practical training about self-harm and suicide within all sectors was raised. Participants felt that training for tutors should be a pre-requisite. Additionally, they identified a specific training need for police and the availability of support and training for parents.

Some participants conveyed a wish to be involved in the development of training, raising awareness, advocacy, and activism, with the aim to challenge assumptions, destigmatise, and demystify, stating that "*I want to use my lived experience to help other people*" (R0012, female, H.E.). They believed that including people with lived experience in education, policy, and training would help others gain a better understanding and, thereby, feel more equipped to support when needed.

4. Discussion

The aim of this research was to present the voice of lived and living experience as accurately and respectfully as possible and to start building bridges towards a kinder, more inclusive approach to suicidality, breaking down barriers and opening channels for further discussion to take place to support colleagues and institutions with an immensely challenging task, faced with cuts to funding and service provision in all public sectors.

It has been theorised that, although risk factors for suicidality are experienced at an individual level, they are heavily influenced by social determinants [10]. As evidenced

by the findings, our study provides new insights into the far-reaching impact of suicide attempt(s) on a person's sense of self, others, and ways of being in the world, as well as one's relationship with mortality, the future, and an unexpected life ahead. To counter this, we need to start breaking down barriers by viewing suicide more as a transitory state of being and acknowledging that some people live alongside suicidal thoughts, always there in some form as part of one's life.

Literature suggests that the majority of students who consider suicide do not access mental health services [46,47] and that, in fact, those perceived to be most in need of services are least likely to access them [48]. Our study reiterates that past experiences of services and reaching out for support have been found to influence potential help-seeking and a positive experience was more likely to lead someone to engage with this [16]. Another barrier identified in the literature and supported by our study was not knowing about resources or the availability of college/university support services [49], as well as the lack of specifically trained and/or experienced mental health professionals on site [50]. Our study suggests that this remains the case and that there is a definite need for a change in the culture to proactive rather than reactive support strategies and reaching out to people experiencing suicidality.

Literature also suggests that students fear stigma from the university structures, with some evidence suggesting students feared that information sharing could affect academic progression and their sense of belonging [16,51]. Again, our findings confirm that this poses an ongoing barrier to disclosure and accessing support.

It has been suggested that, in light of the additional pressures of transitions between education sectors, a possible focus on early intervention for first-year students, and students identifying with one or more of the protected characteristics or mental health challenges [49] could be a proactive measure. Our study shows that the greatest need is to first remove the barriers to access and engagement with support. It supports the literature that draws attention to the need for an inclusive approach to interventions, rather than a generalised approach to suicide prevention, by targeting and tailoring interventions to meet the diverse needs and experiences of students, including students with any of the protected characteristics [52], and cultivating a culture of belonging and inclusivity.

However, as revealed by the findings, some of the support needs are specific to post-suicide attempts and thereby differ from prevention strategies and require a different kind of intervention than that outlined in existing policies [4–7]. This is particularly relevant when considering the challenges identified with the transition to university.

Furthermore, the adjustment to life post-attempt highlights the urgent need to be seen sooner and for consistency in support, and to take into account the recovery time and also the impact of trauma of the attempt itself. This will firstly need to start with destigmatisation, to break down some of the identified barriers and to encourage disclosure. Secondly, finding ways to promote a culture of 'reaching out to'. And, thirdly, consistent, targeted, and focused support for attempt survivors that considers transitional support and ways for support to be joined-up, so that this can be proactively approached and address some of the mitigating factors such as social isolation, pressure, and destabilisation that inevitably comes with change. As evidenced by the findings, the relational qualities of people in support roles are central to this and how organisations can work towards removing some of the barriers that derive from stigma present internally and externally.

4.1. Strengths and Limitations

Within qualitative research, there is a tension to create translatable codes and themes, whilst still doing justice to the unique nature of lived and living experience. The relational approach to interviewing itself was a strength and supported the aim not to speak for, but

to best represent the voices that shared their lived and living experiences with integrity and respect.

Although recruitment reached far and wide across the four nations of the UK, the authors acknowledge the limitations of the non-homogenous nature of the study and that we only heard the voices of people who came forward. Consequently, the findings presented are therefore not necessarily representative of all people experiencing attempted suicide in Further and Higher Education.

Not having an even spread across Further and Higher Education meant that sub-themes, such as transitions, could not be compared. Additionally, not clearly delineating questions about health and educational support meant that these could not be written about separately, unless a particular sector was explicitly stated. However, it is likely that the depth of feeling and wider context would not have been as clear if these questions would have been more structured.

As this was a UK-based study that refers to UK guidance and procedures, and a UK educational and mental health service context, this may make it more difficult for people in other countries to relate to some of the findings. However, many of the themes remain relatable.

4.2. Implications and Future Directions

The study was specific to ages 16–25, but participants were asked when they made their first attempt. Most participants' first suicide attempts pre-dated their 16th birthday, with the earliest recorded at 12 years old. Experiences before F.E. and H.E. were noted and challenges at school and in child and adolescent services had created anticipation and apprehension that particularly affected help-seeking and engagement. Participants spoke of challenges at the time that had deeply affected them. The need for earlier intervention is clear and additional study into school-age suicidality would be beneficial.

Our study identifies a gap in guidance and policy for attempted suicide at university. This is particularly noteworthy, given that attempting suicide is a strong risk factor for a death by suicide [53].

Universities UK and their colleagues have done much work to create pre- and postvention guidance and policy. This has gone some way to address the issues raised; however, the pressure on support providers across all sectors is immense [54]. These operate from a reactive stance due to long waiting lists and financial constraints. A review of funding and human resource allocations is much needed.

Further training to educate about and destigmatise suicide is needed, so that staff can feel empowered to foster more inclusive, compassionate approaches [3,55]. The effects and impact of the depth of emotional pain and trauma on staff are not to be underestimated and it is encouraging that, since the start of the study, colleagues have focused specifically on this [56].

The identification that more targeted and specific support is needed for suicide attempt survivors highlights an area for further studies into the difference in experiences between suicidal thoughts, feelings, and behaviours and how best to support and meet these differing needs.

In a world that is increasingly looking to utilise AI, the human and relational aspects across all data cannot be ignored, particularly when it is so hard for people to reach out. To create a practice of reaching out, we need to reframe current narratives. Campaigns to 'Ask Twice' [57] are helping to encourage this on an interpersonal level, but this needs embedding on an institutional level. A recent announcement stated that a Multi-Modal Approach to Preventing Suicide in Schools (MAPSS) will be taught in schools, specifically targeted at Year 10 students, aged 14 or 15 [58], with trials planned until January 2026.

Additional training in suicide prevention will be offered to teachers and parents. This feels to be a helpful step towards affecting change, but we will be interested in the feedback from young people, teachers, and parents with lived and living experience of/supporting individuals with suicidality.

Our findings suggest that the biggest challenge remains stigma and what is evident across the data is the need to depathologise suicide and address the fear that creates barriers to both support provision and the access to it.

5. Conclusions

Much of the literature and current policy frameworks focus on suicide prevention and postvention. Close analysis of these documents and the findings from our study highlights a gap in policy for students who have attempted suicide.

Efforts are already being made to fight the tide and the confirmation that one specific person can make the difference between life and death and can provide a glimmer of hope in a hopeless place. To honour the voices presented in this article, a participant quotation is included to stress this point:

> "*So the main message that I would give to people who attempted suicide. . .you will meet hopefully that one person who will change everything in your life.*"
>
> (R0021, male, F.E.)

Kindness and compassion, breaking down barriers, and challenging stigma all impact how a person feels met and understood in the world. It is hoped that this research supports a growing understanding in both education and society that the relational aspects are the biggest barrier, and that this article in some way goes towards bridging this.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/healthcare13243222/s1, File S1: Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist. File S2: Interview questions–Learning from Further and Higher Education students' lived experiences of attempted suicide.

Author Contributions: Conceptualisation, J.S., L.M. and E.C.; methodology J.S., L.M. and E.C.; formal analysis, J.S.; investigation, J.S.; resources, J.S.; data curation, J.S.; writing—original draft preparation, J.S.; writing—review and editing, L.M. and E.C.; supervision, L.M. and E.C.; project administration, J.S.; funding acquisition, J.S. All authors have read and agreed to the published version of the manuscript.

Funding: This research was part-funded by Johnson Resolutions.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Psychology Ethics Committee of Middlesex University, application number: 7390, 14 November 2019, Version 1.

Informed Consent Statement: Informed consent was obtained from all participants involved in this study.

Data Availability Statement: The raw data are not publicly available as they include qualitative quotes that could compromise the privacy of the research participants.

Acknowledgments: The authors would like to warmly thank all the participants who took part in the study, the Participatory Research Group, Andreas Muller for his guidance and training in MAXQDA, Jo Kirby for her support with transcription, Johnson Resolutions for their support with funding, Lisa Reed for her insightful clinical supervision, Samaritans for their support provision with spaces for in-person interviewing, and everyone who has advocated for the research work and supported the process.

Conflicts of Interest: The authors declare that this study received funding from Johnson Resolutions. The funder was not involved in the study design, collection, analysis, interpretation of data, the writing of this article or the decision to submit it for publication.

References

1. Gunnell, D.; Caul, S.; Appleby, L.; John, A.; Hawton, K. The incidence of suicide in university students in England and Wales 2000/2001–2016/2017: Record linkage study. *J. Affect. Disord.* **2020**, *261*, 113–120. [CrossRef]
2. Kabira, R.; Syeda, H.Z.; Vinnakotab, D.; Okelloa, S.; Isigia, S.S.; Kareema, S.K.A.; Parsaa, A.D.; Arafat, S.M.Y. Suicidal behaviour among the university students in the UK: A systematic review. *Heliyon* **2024**, *10*, e24069. [CrossRef] [PubMed]
3. Rodway, C.; Tham, S.G.; Turnbull, P.; Kapur, N.; Appleby, L. National Review of Higher Education Student Suicide Deaths. National Confidential Inquiry into Suicide and Safety in Mental Health. Department for Education/University of Manchester; 2025. Available online: https://www.gov.uk/government/publications/national-review-of-higher-education-student-suicide-deaths (accessed on 29 August 2025).
4. Fox, T.; Smith, J. A model for suicide prevention in Higher Education. In *Preventing and Responding to Student Suicide. A Practical Guide for FE and HE Settings*; Mallon, S., Smith, J., Eds.; Jessica Kingsley Publishers: London, UK, 2022.
5. AMOSSHE. 2024. Available online: https://www.amosshe.org.uk/resource/collective-responsibility-collective-action-to-prevent-student-suicide-1.html (accessed on 29 August 2025).
6. Universities UK. Suicide Safer Universities. 2018. Available online: https://www.universitiesuk.ac.uk/what-we-do/policy-and-research/publications/features/suicide-safer-universities (accessed on 29 August 2025).
7. Universities UK. Responding to Suicide: Advice for Universities. 2022. Available online: https://www.universitiesuk.ac.uk/what-we-do/policy-and-research/publications/features/suicide-safer-universities/responding-suicide-advice-universities (accessed on 29 August 2025).
8. Cameron, G.C.; Hunter, S.C.; McCartney, R.C.; McKain, L. A systematic review of the barriers associated with help-seeking among students at risk of suicide. *Educ. Res. Eval.* **2024**, *30*, 190–211. [CrossRef]
9. Grollman, E. *Suicide: The Philosophical Dimensions*; Cholbi, M., Ed.; Broadview Press: Peterborough, ON, Canada, 2011; p. 159.
10. Pirkis, J.; Bantjes, J.; Dandona, R.; Knipe, D.; Pitman, A.; Robinson, J.; Silverman, M.; Hawton, K. Addressing Key risk factors for suicide at a societal level. *Lancet Public Health* **2024**, *9*, e816–e824. [CrossRef] [PubMed]
11. Drum, D.; Brownson, C.; Hess, E.A.; Denmark, A.B.; Talley, A.E. College Students' Sense of Coherence and Connectedness as Predictors of Suicidal Thoughts and Behaviors. *Arch. Suicide Res.* **2017**, *21*, 169–184. [CrossRef]
12. Rimkeviciene, J.; Hawgood, J.; O'Gorman, J.; De Leo, D. Personal Stigma in Suicide Attempters. *Death Stud.* **2015**, *39*, 592–599. [CrossRef]
13. Williams, S.; Langhinrichsen-Rohling, J.; Wornell, C.; Finnegan, H. Adolescents transitioning to High School: Sex differences in bullying victimization associated with depressive symptoms, suicide ideation, and suicide attempts. *J. Sch. Nurs.* **2017**, *33*, 467–479. [CrossRef]
14. Lasgaard, M.; Goossens, L.; Elklit, A. Loneliness, Depressive Symptomatology, and Suicide Ideation in Adolescence: Cross-Sectional and Longitudinal Analyses. *J. Abnorm. Child Psychol.* **2011**, *39*, 137–150. [CrossRef]
15. Samaritans. Loneliness, Suicide and Young People. 2019. Available online: https://media.samaritans.org/documents/loneliness-suicide-young-people-jan-2019.pdf (accessed on 31 January 2019).
16. Kearns, M.; Muldoon, O.; Msetfi, R.; Surgenor, P. Understanding help-seeking amongst university students: The role of group identity, stigma, and exposure to suicide and help-seeking. *Front. Psychol.* **2015**, *6*, 1462. [CrossRef]
17. Ploskonka, R.; Servaty-Seib, H. Belongingness and suicidal ideation in college students. *J. Am. Coll. Health* **2015**, *63*, 81–87. [CrossRef]
18. Gautam, A.; Kumar, U. Perceived stress, self-efficacy and reasons for living as predictors of suicidal ideation. *J. Psychosoc. Res.* **2014**, *9*, 351–359.
19. Hatchel, T.; Merrin, G.; Espelage, D. Peer victimisation and suicidality among LGBTQ youth: The roles of school belonging, self-compassion, and parental support. *J. LGBT Youth.* **2018**. [CrossRef]
20. Kelliher Rabon, J.; Sirois, F.; Hirsch, J. Self-compassion and suicidal behavior in college students: Serial indirect effects via depression and wellness behaviors. *J. Am. Coll. Health* **2018**, *66*, 114–122. [CrossRef] [PubMed]
21. Stänicke, L.; Haavind, H.; Gullestad, S. How do young people understand their own self-harm? A meta-synthesis of adolescents' subjective experience of self-harm. *Adolesc. Res. Rev.* **2018**, *3*, 173–191. [CrossRef]
22. DeCou, C.; Kaplan, S.; Spencer, J.; Lynch, S. Trauma-related shame, sexual assault severity, thwarted belongingness, and perceived burdensomeness among female undergraduate survivors of sexual assault. *Crisis J. Crisis Interv. Suicide Prev.* **2019**, *40*, 134–140. [CrossRef]
23. Ebert, D.; Buntrock, C.; Mortier, P.; Auerbach, R.; Weisel, K.; Kessler, R.; Cuijpers, P.; Green, J.; Kiekens, G.; Nock, M.; et al. Prediction of major depressive disorder onset in college students. *Depress. Anxiety* **2019**, *36*, 294–304. [CrossRef]

24. Bruffaerts, R.; Mortier, P.; Kiekens, G.; Auerbach, R.; Cuijpers, P.; Demyttenaere, K.; Green, J.; Nock, M.; Kessler, R. Mental health problems in college freshmen: Prevalence and academic functioning. *J. Affect. Disord.* **2018**, *225*, 97–103. [CrossRef]
25. Mortier, P.; Demyttenaere, K.; Auerbach, R.; Green, J.; Kessler, R.; Kiekens, G.; Nock, M.; Bruffaerts, R. The impact of lifetime suicidality on academic performance in college freshmen. *J. Affect. Disord.* **2015**, *186*, 254–260. [CrossRef]
26. O'Neill, S.; McLafferty, M.; Ennis, E.; Lapsley, C.; Bjourson, T.; Armour, C.; Murphy, S.; Bunting, B.; Murray, E. Socio-demographic, mental health and childhood adversity risk factors for self-harm and suicidal behaviour in College students in Northern Ireland. *J. Affect. Disord.* **2018**, *239*, 58–65. [CrossRef] [PubMed]
27. Taub, D.; Thompson, J. College student suicide. *New Dir. Stud. Serv.* **2013**, *2013*, 5–14. [CrossRef]
28. Brownson, C.; Drum, D.; Swanbrow Becker, M.; Saathoff, A.; Hentschel, E. Distress and Suicidality in Higher Education: Implications for Population-Oriented Prevention Paradigms. *J. Coll. Stud. Psychother.* **2016**, *30*, 98–113. [CrossRef]
29. Lehman, M.; Hillimire, M.; Yang, L.; Link, B.; DeVylder, J. Investigating the relationship between self-esteem and stigma among young adults with history of suicide attempts. *J. Crisis.* **2016**, *37*, 265–270. [CrossRef]
30. Klimes-Dougan, B.; Klingbeil, D.; Meller, S. The impact of universal suicide-prevention programs on the help-seeking attitudes and behaviors of youths. *Crisis* **2013**, *34*, 82–97. [CrossRef] [PubMed]
31. Marsh, I. Critiquing contemporary suicidology. In *Critical Suicidology: Transforming Suicide Research and Prevention for the 21st Century*; White, J., Marsh, I., Kral, M.J., Morris, J., Eds.; UBC Press: Vancouver, BC, Canada, 2016; pp. 15–30.
32. Cesar Riani Costa, L.; White, J. Making Sense of Critical Suicide Studies: Metaphors, Tensions, and Futurities. *Soc. Sci.* **2024**, *13*, 183. [CrossRef]
33. Colucci, E. Sociocultural Context of Suicidal Behavior—Its Importance and Neglect. In *Suicide and Culture 2.0*; Colucci, E., Lester, D., Eds.; Hogrefe: Amsterdam, The Netherlands, 2025; pp. 3–39.
34. Beames, J.R.; Kikas, K.; O'Gradey-Lee, M.; Gale, N.; Werner-Seidler, A.; Boydell, K.M.; Hudson, J.L. A New Normal: Integrating Lived Experience into Scientific Data Syntheses. *Front. Psychiatry* **2021**, *12*, 763005. [CrossRef]
35. Smit, J.; Colucci, E.; Marzano, L. Unspoken, Unseen, Unheard: Using Arts-Based and Visual Research Methods to Gain Insights into Lived Experiences of Suicide in Young Adults. *Soc. Sci.* **2025**, *14*, 62. [CrossRef]
36. Tong, A.; Sainsbury, P.; Craig, J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *J. Int. Qual. Health Care* **2007**, *19*, 349–357. [CrossRef]
37. Braun, V.; Clarke, V. *Thematic Analysis. A Practical Guide*; SAGE Publications Ltd.: London, UK, 2022.
38. Bhaskar, R. *A Realist Theory of Science*; Routledge: New York, NY, USA, 1975.
39. Wynn, D.; Williams, C. Principles for Conducting Critical Realist Case Study Research in Information Systems. *J. MIS Q.* **2011**, *36*, 787–810. [CrossRef]
40. VERBI Software. *MAXQDA 2022 [Computer Software]*, VERBI Software: Berlin, Germany, 2021. Available online: https://www.maxqda.com/ (accessed on 2 December 2022).
41. Strauss, A.; Corbin, J.M. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*; Sage Publications, Inc.: London, UK, 1990.
42. Braun, V.; Clarke, V. To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qual. Res. Sport Exerc. Health* **2019**, *13*, 201–216. [CrossRef]
43. Tight, M. Saturation: An Overworked and Misunderstood Concept? *Qual. Inq.* **2023**, *30*, 577–583. [CrossRef]
44. Winnicott, D. *Playing and Reality*; Routledge: Oxford, UK; Taylor & Francis Group: Abingdon, UK, 2005.
45. Carr, S. *All the Lonely People*; Pan Macmillan: London, UK, 2024.
46. Brownson, C.; Drum, D.; Smith, S.; Bruton Denmark, A. Differences in suicidal experiences of male and female undergraduate and graduate students. *J. Coll. Stud. Psychother.* **2011**, *24*, 2770294. [CrossRef]
47. Sise, C.; Smith, A.; Skiljan Sack, D.; Rivera, L.; Sise, M.; Osler, T. Suicidal and help-seeking behaviors among college freshmen. *J. Trauma Nurs.* **2011**, *18*, 89–96. [CrossRef]
48. Taliaferro, L.; Muehlenkamp, J. Risk factors associated with self-injurious behavior among a national sample of undergraduate college students. *J. Am. Coll. Health* **2015**, *63*, 40–48. [CrossRef]
49. Cerel, M.; Chandler, B.; Moore, M. Suicide exposure, awareness and attitudes in college students. *Adv. Ment. Health* **2013**, *12*, 46–53. [CrossRef]
50. Paladino, D.; Minton, C. Comprehensive college student suicide assessment: Application of the BASIC ID. *J. Am. Coll. Health* **2008**, *56*, 643–650. [CrossRef]
51. Lockman, J.; Servaty-Seib, H. College student suicidal ideation: Perceived burdensomeness, thwarted belongingness, and meaning made of stress. *Death Stud.* **2016**, *40*, 154–164. [CrossRef] [PubMed]
52. Lamis, D.; Lester, D. Gender Differences in Risk and Protective Factors for Suicidal Ideation Among College Students. *J. Coll. Stud. Psychother.* **2013**, *27*, 62–77. [CrossRef]
53. Favril, L.; Yu, R.; Geddes, J.; Fazel, S. Individual-level risk factors for suicide mortality in the general population: An umbrella review. *Lancet Public Health* **2023**, *8*, e868–e877. [CrossRef] [PubMed]

54. Hughes, G.; Priestley, M.; Spanner, L. Stretched at Both Ends: Pressure on Student Services and the Impact on Academic Staff at UK Universities. *Educ. Sci.* **2025**, *15*, 13. [CrossRef]
55. Dickens, C.; Guy, S. How can we support staff to talk safely about suicide? In *Preventing and Responding to Student Suicide. A Practical Guide for FE and HE Settings*; Mallon, S., Smith, J., Eds.; Jessica Kingsley Publishers: London, UK, 2022.
56. Causer, H.; Bradley, E.; Muse, K.; Smith, J. Bearing witness: A grounded theory of the experiences of staff at two United Kingdom Higher Education Institutions following a student death by suicide. *PLoS ONE* **2021**, *16*, e0251369. [CrossRef]
57. Time to Change. 2022. Available online: https://www.time-to-change.org.uk/asktwice (accessed on 29 August 2025).
58. Liverpool John Moores University. 2024. Available online: https://www.ljmu.ac.uk/about-us/news/articles/2024/2/2/suicide-schools-project (accessed on 29 August 2025).

healthcare

MDPI

Article

Psychological Strain and Suicide Rumination Among University Students: Exploring the Mediating and Moderating Roles of Depression, Resilient Coping, and Perceived Social Support

Nuri Türk [1], Mustafa Özmen [2] and Sümeyye Derin [3,4,*]

[1] Department of Guidance and Psychological Counselling, Faculty of Education, Siirt University, 56100 Siirt, Türkiye; nuri.turk@siirt.edu.tr
[2] Department of Child Care and Youth Services, Vocational School of Health Services, Bingöl University, 12000 Bingöl, Türkiye; mozmen@bingol.edu.tr
[3] Youth Studies Research & Application Center, Sakarya University, 54050 Sakarya, Türkiye
[4] Department of Psychology, Faculty of Humanities and Social Sciences, Sakarya University, 54050 Sakarya, Türkiye
* Correspondence: sumeyyederin@sakarya.edu.tr; Tel.: +90-264-295-60-81

Abstract

Background/Objectives: Suicide is among the biggest causes of death in the world. In recent years, suicide rates have increased remarkably in developing countries such as Türkiye. Therefore, there is a need to understand the psychological mechanisms underlying suicidal ideation and behaviors. Within this context, this study aimed to examine the complex relationships between psychological strain and suicide rumination. **Methods**: The study was conducted on 470 university students because young adults constitute the largest suicide risk group in Türkiye. **Results**: The findings showed that psychological strain was a significant predictor of suicide rumination. Additionally, depression was found to play a mediating role between psychological strain and suicide rumination. Furthermore, both resilient coping and perceived social support were shown to play a moderating role in the relationships among psychological strain, depression, and suicide rumination. The results confirmed the Strain Theory of Suicide in a sample from Türkiye. **Conclusions**: These findings are expected to contribute to psychologists, psychiatrists and public health specialists' development of suicide prevention and intervention programs for university students. These suicide prevention and intervention efforts may focus on enhancing resilient coping and perceived social support in combating psychological strain and depression.

Keywords: suicide rumination; psychological strain; depression; resilient coping; perceived social support

1. Introduction

Suicide is seen as a common public health problem in many countries around the world, with 726,000 people dying by suicide every year [1]. Suicide attempts are known to be at least 20 times more common than completed suicides [2]. Furthermore, according to a study conducted in 2018, there are at least 135 people who directly and indirectly recognize a person who has died by suicide [3]. Therefore, approximately 100 million people are exposed to the effects of suicide every year. This situation reveals the breadth of the impact of suicide, which is characterized as a social bomb [4].

Suicide is the third leading cause of death, especially among individuals aged 15–29 [1]. Suicide cases among university students in this age group have shown a remarkable increase in the last 10 years [5]. Türkiye is among the countries where such an increase is observed. According to 2023 suicide reports, Türkiye has reached the highest suicide rate (4.94 per 100,000) in its history [6]. Within this rate, the group with the highest number of suicide cases includes individuals between the ages of 20 and 29. These individuals in the quarter-life crisis age range are assumed to be going through a chaotic period due to identity confusion, uncertainty about the future, and conflicts in romantic and family relationships [7]. This transition period, during which it is difficult to respond to the requirements of life, increases the likelihood of experiencing various mental problems that may result in suicide [8]. In a study conducted on young adults, mostly university students in Türkiye, psychological vulnerability and emotional problems (depression, anxiety, somatization) were found to be significant predictors of suicidal ideation [9]. According to another study conducted with Turkish university students, defeat, entrapment, and thwarted belongingness were reported to be significantly positively associated with suicidal ideation [10].

To prevent the suicidal thoughts and behaviors of university students in Türkiye, research is needed to discover new risk and protective factors. Although thousands of studies have been conducted on suicide, new theoretical and practical research continues in light of the debate on the predictability and randomness of suicide [11,12]. Within this context, there are many first- and second-generation theories of suicide used to explain suicide [13]. One of these theories is the Strain Theory of Suicide (STS), developed by Zhang [14]. According to Zhang, psychological strain caused by four different sources leads to suicide [14]. These sources include value strain, aspiration strain, deprivation strain, and coping strain. Value strain refers to the conflict between social values that are of similar importance to the individual, while aspiration strain arises from the conflict between the actual situation and the individual's aspirations. Deprivation strain is the individual's feeling that he/she leads a worse life than people who he/she thinks have similar backgrounds, and coping strain is the individual's feeling of helplessness in the face of life crises [15].

Psychological strain refers to the strain experienced by individuals when confronted with two equally important and contradictory situations. This strain can disrupt the psychological balance of the individual and cause psychological pain accompanied by disappointment, depression, and restlessness. Individuals who want to get rid of psychological pain and regain balance may see suicide as a solution [16]. Significant positive correlations between psychological strain and suicidal ideation have been found in university students from different cultures [17]. Within this context, the present study suggests that psychological strain may predict suicidal rumination, which includes suicidal ideations. When suicidal ideations and plans become repetitive, they turn into suicidal rumination [18]. Suicide-specific rumination is known to be the strongest risk factor for lifelong suicide attempts [19]. Suicide rumination includes mental obsessions during the transition from suicidal ideations to suicidal behaviors. Therefore, studies on suicidal rumination contribute to the identification of high-risk groups in different cultures by determining the frequency and severity of suicidal ideations [20,21].

Depression, which is associated with both rumination and psychological strain [22], is shown to be among the important risk factors for suicide. Meta-analysis studies on mental health risk factors of university students, in particular, show that depression is still effective in explaining suicidal ideation and behavior [23,24]. Additionally, psychological strain is known to be a significant predictor of depression in university students [25]. Studies show that the relationship between psychological strain and suicidal ideation

is explained by depression [26]. Additionally, depressive thinking and rumination are often seen together [27,28]. Indeed, Nolen-Hoeksema et al. argue that rumination is a form of repetitive negative thinking in which the individual focuses his/her attention on depressive symptoms [29]. Rumination, a cognitive vulnerability factor, increases the duration and severity of depression and strengthens the possibility of suicide [22]. Furthermore, depression was found to significantly predict suicide rumination according to a study conducted on university students [30]. Consequently, psychological strain predicts depression, while depression predicts suicide rumination. Within this context, it is thought that depression could mediate the relationship between psychological strain and suicide rumination.

Depression plays a mediating role in the relationship between coping strain, which is a sub-dimension of psychological strain, and suicidal ideation [31]. This finding shows the importance of the inadequacy of coping mechanisms in psychological strain leading to depression. Coping methods accompanied by resilience are especially known to be protective factors against suicide in university students [32]. Furthermore, according to an empirical study, resilient coping was found to reduce the risk of suicide [33]. Resilient coping is one of the effective methods for adaptively overcoming strain and stress. Individuals with resilient coping are goal-oriented individuals who believe that they can cope with challenging circumstances [34]. Studies conducted on university students have found that resilient coping has positive correlations with optimism and life satisfaction and negative correlations with depression and anxiety [35,36]. Therefore, resilient coping may moderate the effect of psychological strain on depression by buffering inadequate coping caused by psychological strain.

One of the protective factors against suicide is perceived social support. Perceived social support has a significant negative relationship with suicide as well as with many risky behaviors [37]. Additionally, it is known that social support moderates the effect of psychological strain on suicidality in university students [38]. Therefore, perceived social support may have a moderating effect on depression predicted by psychological strain and suicide rumination. Indeed, perceived social support plays a critical role in coping with depression in university students [39]. University students who can develop healing social relationships have less difficulty coping with depressive moods. This coping method reduces the effect of depression on hopelessness, which is one of the main causes of suicidal thoughts [40]. Within the framework of this literature, perceived social support is expected to play a moderating role in the relationship between depression and suicide rumination.

The Present Study

Psychological strain, the main concept of the Strain Theory of Suicide (STS), is seen as the source of the pain that leads to suicide. The pain and strain that occur as a result of the conflict between the realities of life and the ideals of individuals can increase the frequency and severity of suicidal ideations [16]. However, the variables underlying this linear relationship between psychological strain and suicide are not yet sufficiently known. Therefore, the present study aimed to examine the role of depression, resilient coping, and perceived social support in the relationship between psychological strain and suicide rumination. Additionally, there is a need for in-depth research on the causes and consequences of suicide among university students, who are among the highest suicide risk age groups in Türkiye. Therefore, this study is expected to guide suicide prevention studies for university students going through a challenging period full of uncertainties.

In this study, the mechanisms underlying the relationship between psychological strain and suicide rumination were examined. Within this context, based on the theoretical

and empirical findings in the literature, the following research questions (RQs) were tested in the present study:

1. Does psychological strain predict suicide rumination?
2. Does depression have a mediating effect on the relationship between psychological strain and suicide rumination?
3. Does resilient coping have a moderating effect on the relationship between psychological strain and depression?
4. Does perceived social support have a moderating effect on the relationship between depression and suicide rumination?

2. Materials and Methods

2.1. Participants

This study was conducted with 470 university students, taking into account the minimum number recommended by G*Power, version 3.1. Of these, 73.6% were female (n = 346) and 26.4% (n = 124) were male. Their ages ranged from 16 to 47 years, with a mean age of 24.93 (SD = 3.77). According to socioeconomic status, 105 (22.3%) participants reported low socioeconomic status, 354 (75.3%) reported medium socioeconomic status, and 11 (2.3%) reported high socioeconomic status.

2.2. Instruments

- Sociodemographic data. It was administered to obtain information about the sociodemographic characteristics (e.g., age, gender etc.) of the participants.
- Psychological Strain Scales-Short Form (PSS-SF). PSS-SF was developed by Zhang et al. [41]. The short form of PSS-SF was developed by Huen et al. [42]. PSS-SF was adapted into Turkish by Özmen et al. (43/submitted for publication). Each item is scored between 1 (strongly disagree) and 5 (strongly agree). PSS-SF is a 5-item scale developed to determine the level of psychological strain experienced by the person. High scores indicate high levels of psychological strain. Sample item: 'Even if I can't change, I would like to live in a better family.' PSS-SF has shown good reliability in previous studies (α = 0.80; [42]). The psychometric properties of PSS-SF were examined while it was adapted to Turkish by Özmen et al. [43]. The results showed that, as in the original version, the scale had a single-factor structure and good fit values. Furthermore, the current study re-examined the scale's CFA and reliability values. The CFA of the scale showed that the fit values were at an excellent level (χ^2/df = 1.88; RMSEA = 0.04; CFI = 0.99; IFI = 0.99; GFI = 0.99; NFI = 0.98; TLI = 0.98; RFI = 0.96). PSS-SF has shown reliability above the acceptance limits in the current study (α = 0.72).
- Suicide Rumination Scale (SRS). The SRS is a 6-item scale developed to assess recurrent suicidal ideation [18,44]. The SRS is scored from 1 (strongly disagree) to 5 (strongly agree). High scores on the scale indicate high ruminative suicidal ideation. Sample item: "I have difficulty getting suicidal thoughts out of my mind". In this study, the SRS demonstrated excellent reliability (α = 0.95).
- Depression Anxiety Stress Scale 8 (DASS-8). The DASS-8 [45] comprises eight items and three subscales: depression (e.g., "I feel down and blue"; three items), anxiety (e.g., "I worry about situations where I might panic and make a fool of myself"; three items), and stress (e.g., "I feel under a lot of stress"; two items). The cut-off points for depression and anxiety were normal (0–3), moderate (4–6), and severe (7–9), while the cut-off points for stress were normal (0–2), moderate (3–4), and severe (5–6). This study examined the validity and reliability of the scale.

- Brief Resilient Coping Scale (BRCS). The BRCS [34,46] was used to assess resilient coping and was adapted into Turkish by Özmen et al. (43/submitted for publication). Each item is scored between 1 (does not describe me at all) and 5 (describes me very well). The BRCS is a 4-item scale that assesses a person's level of resilient coping in the face of stressful and destructive life events. Sample item: 'I believe that I can develop positively by coping with difficult situations.' Previous studies have also shown that BRCS has good reliability ($\alpha = 0.85$; [47]). The psychometric properties of BRCS were examined while it was adapted to Turkish by Özmen et al. [43]. The results showed that, as in the original version, the scale had a single-factor structure and good fit values. Furthermore, the current study re-examined the scale's CFA and reliability values. The CFA of the scale showed that the fit values were at an excellent level ($\chi^2/df = 2.56$; RMSEA = 0.06; CFI = 0.99; IFI = 0.99; GFI = 0.99; NFI = 0.99; TLI = 0.99; RFI = 0.98). The scale showed good reliability in the current study ($\alpha = 0.84$).
- Perceived Social Support Questionnaire (F-SozU K-3). The F-SozU K-3 [48] is a 3-item scale developed as a brief screening instrument. Each item is scored between 1 (not true at all) and 5 (very true). The F-SozU K-3 assesses the level of social support perceived by the individual in the face of any negative experience. Sample item: 'When I feel down, I know who I can go to without hesitation.' The F-SozU K-3 showed good reliability in the original study ($\alpha = 0.80$; [48]). This study examined the validity and reliability of the scale.

2.3. Procedure

The first author obtained approval for this study from the Siirt University Ethics Committee (Date: 9 January 2025, reference number: 8241). Data collection took place in February and March 2025. The sample consisted of active students studying in the department of social work. The data were collected via the WhatsApp application in academic classrooms where university students were present. A consent form was presented to all participants both verbally during the application phase and in writing at the beginning of the questionnaire. The questionnaire was administered to university students in a quiet environment free of distracting stimuli. All participants were informed that they could withdraw from the study at any stage. No reward, points, or gifts were given to the participants, as this would not align with normative values in Türkiye. The participants were assured that no personal data would be collected and that the data would be analyzed in groups. All stages of the study were conducted in accordance with the provisions of the Declaration of Helsinki.

2.4. Data Analysis

IBM SPSS Version 27 and AMOS Version 25 were used for data analysis. Data analysis consisted of two stages. In the first stage, the DASS-8 and F-SozU K-3 were adapted. Analyses related to the adaptation of the DASS-8 and F-SozU K-3 into Turkish were performed. It was assumed that a model with an RMSEA value <0.05 indicates a good model, while values between 0.05 and 0.08 indicate acceptable fit. Other modification fit index values CFI, RFI, GFI, IFI, NFI, and TLI > 0.95 were accepted as indicators of good fit [49–51]. The model was then tested in the second stage. First, the participants (n = 22) who incorrectly marked the control item were excluded from the analysis, as this would reduce the reliability of the data. Second, the normality assumptions of the data were examined [52]. Third, the mediation effect of depression was tested using the SPSS PROCESS macro model 4 proposed by Hayes [53]. Fourth, the SPSS PROCESS macro model 21 proposed by Hayes [53] was used to check whether the conditional indirect effect

of perceived social support and resilient coping in the relationship between psychological strain and suicidal rumination was significant. Fifth, for the significance of direct and indirect effects, confidence intervals not covering zero with 5000 resamples were taken as a reference [54].

3. Results

3.1. Psychometric Properties of DASS-8 and F-SozU K-3

Translation and back-translation procedures were applied during the adaptation of the scales to Turkish [55]. The scale items were translated into Turkish by three field expert academicians fluent in Turkish and English. Two field expert academicians reviewed the translation in terms of clarity and cultural appropriateness of the questions. To examine the grammar of the translated scales, they were back-translated into English by two academicians working in the English department. The suitability of the scales for Turkish was examined by two Turkish teachers. Necessary corrections were made to the scales in line with the feedback provided after all examinations. In the validity and reliability analyses of the scales, Exploratory Factor Analysis (EFA) was performed with 230 data points; following this, Confirmatory Factor Analysis (CFA) was performed with 240 data points.

According to the EFA results for the DASS-8 scale, the KMO value was 0.89 and the p value in the Bartlett test was significant (910.623 ($p < 0.000$). The scale items explained 51% of the total variance. The factor loadings of the scale items ranged between 0.48 and 0.78. CFA of the scale showed that the fit values were above the acceptance limits ($\chi^2/df = 2.52$; RMSEA = 0.08; CFI = 0.97; IFI = 0.97; GFI = 0.96; NFI = 0.95; TLI = 0.95; RFI = 0.92). To examine convergent validity, the correlation coefficients between the total score of DASS-8 and other research variables were calculated. Psychological distress, which is the total DASS-8 score, is associated with depression (r = 0.87), anxiety (r = 0.90), and stress (r = 0.86). SRS is also moderately correlated with depression (r = 0.48), anxiety (r = 0.38), and stress (r = 0.35). The relationship between DASS-8 and BRCS confirms discriminant validity. BRCS correlates with depression (r = −0.21), anxiety (r = −0.24), and stress (r = −0.17) with low magnitude. Additionally, as a result of the analysis, the CR and AVE values of the scale were found to be 0.93 and 0.57, respectively. The DASS-8 indicated good reliability for depression ($\alpha = 0.81$), anxiety ($\alpha = 0.81$), and stress ($\alpha = 0.78$) in the present study. The total DASS-8 score, indicating psychological distress, also has a good level of reliability ($\alpha = 0.89$).

According to the EFA results for the F-SozU K-3 scale, the KMO value was 0.62 and the p value in the Bartlett test was significant (97.070 ($p < 0.000$). The scale items explained 40% of the total variance. The factor loadings of the scale items varied between 0.52 and 0.79. CFA indicated excellent fit (df = 0.00/0 = 0.00, CFI = 1.00, GFI: 1.00, NFI = 1.00, NFI = 1.00, RMSEA = 0.00, SRMR = 0.00). Similarly, the F-SozU K-3 also had excellent fit index values in the original study [48]. However, since the factor loadings are high as in the original study [48], all three items of the scale can be accepted as meaningful indicators. To examine convergent validity, correlation coefficients between the F-SozU K-3 score and other research variables were calculated. F-SozU K-3 was moderately correlated with BRCS (r = 0.30) and SRS (r = −0.27), which confirms convergent validity. In addition, F-SozU K-3 is associated with depression (r = −0.18), anxiety (r = −0.18), and stress (r = −0.15) in small dimensions. Furthermore, as a result of the analysis, the CR and AVE values of the scale were found to be 0.82 and 0.60, respectively. The F-SozU K-3 showed good reliability in the present study ($\alpha = 0.82$). As a result, it can be said that the validity and reliability values of the F-SozU K-3 scale are at an acceptable level.

3.2. Model Analyses

Before testing model 21, we examined the mean, standard deviation, normality values, and correlation coefficients of the variables. Table 1 shows that the research variables met the normality assumptions. However, psychological strain was negatively associated with perceived social support and resilient coping, whereas it was positively associated with depression and suicide rumination. Perceived social support is negatively related to depression and suicide rumination, and positively related to resilient coping. Finally, depression is positively related to suicide rumination and negatively related to resilient coping.

Table 1. Descriptive statistics.

	Descriptive Statistics and Reliabilities					**Correlations**				
Variables	***M***	***SD***	**Skewness**	**Kurtosis**	**α**	**1**	**2**	**3**	**4**	**5**
1. Psychological strain	2.76	0.91	0.24	−0.40	0.72	-				
2. PSS	3.67	1.19	−0.70	−0.51	0.82	−0.29 **	-			
3. Depression	1.38	0.81	0.46	−0.67	0.81	0.45 **	−0.18 **	-		
4. Resilient coping	3.67	1.01	−0.66	0.11	0.84	−0.20 **	0.30 **	−0.23 **	-	
5. Suicide rumination	1.56	1.01	2.11	3.66	0.95	0.39 **	−0.27 **	0.47 **	0.31 **	-

Note. PSS = Perceived Social Support; ** $p < 0.01$.

3.3. Testing for Mediation Effect

For RQ1, the total effect was analyzed to examine whether psychological strain predicts suicidal rumination. After controlling for age, gender, and socioeconomic status, psychological strain strongly positively predicted suicide rumination in total ($\beta = 0.44$, t = 8.87, $p < 0.001$). For RQ2, whether depression has a mediating effect on the relationship between psychological strain and suicidal rumination was tested. SPSS macro model 4 was used to test this model (Figure 1). First, the predictive relationships in the variables were discussed, and then the mediating effect was analyzed. After controlling for age, gender, and socioeconomic status, psychological strain positively predicted depression ($\beta = 0.39$, $t = 10.33$, $p < 0.001$). Similarly, psychological strain positively predicted suicide rumination ($\beta = 0.25$, $t = 4.90$, $p < 0.001$). Depression positively predicted suicide rumination ($\beta = 0.47$, $t = 8.54$, $p < 0.001$). The total effect between psychological strain and suicidal rumination was also positively significant ($\beta = 0.44$, $t = 8.87$, $p < 0.001$). Finally, after controlling for covariates, depression had a strong mediating effect on the relationship between psychological strain and suicidal rumination (indirect effect = 0.19, $SE = 0.04$, 95% CI = [0.1201, 0.2608]).

3.4. Moderated Mediation Analyses

PROCESS macro model 21 was used to conduct moderated mediation analyses. For RQ3, whether resilient coping moderated the first stage of the mediator in the relationship between psychological strain and suicidal rumination was tested. As seen in Table 2 and Figure 2, there is a moderating effect of resilient coping on the effect of psychological strain on depression. The association of psychological strain with depression was stronger among individuals with low levels of resilient coping ($\beta = 0.44$, $SE = 0.05$, 95% CI = [0.3438, 0.5356]) than among individuals with high levels of resilient coping ($\beta = 0.29$, $SE = 0.05$, 95% CI = [0.1912, 0.3938]). However, the indirect association of psychological strain via depression with suicide rumination was stronger among individuals with low levels of resilient coping ($\beta = 0.21$, $SE = 0.04$, 95% CI = [0.1346, 0.2855]) than among individuals with high levels of resilient coping ($\beta = 0.14$, $SE = 0.03$, 95% CI = [0.0769, 0.2068]).

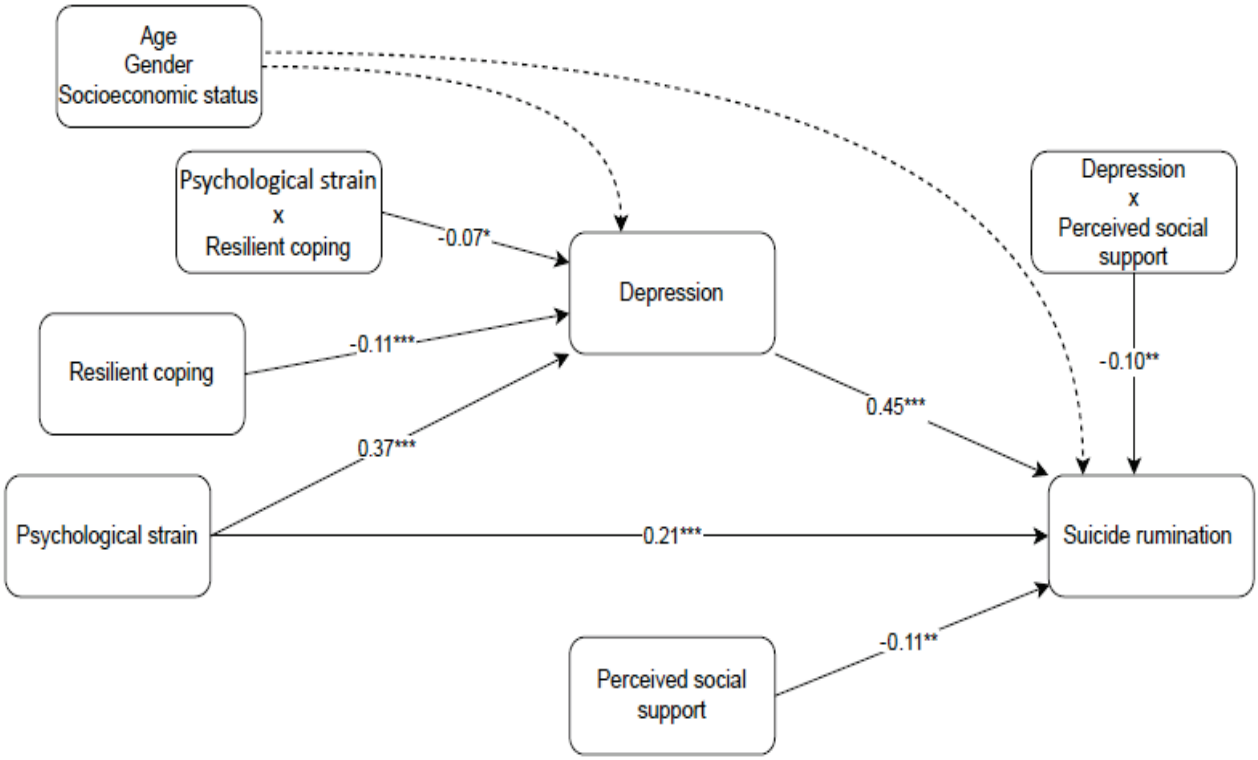

Figure 1. The moderated mediation model. Path coefficients are standardized regression coefficients. * $p < 0.10$, ** $p < 0.01$, *** $p < 0.001$.

Table 2. Conditional effect coefficients predicting suicide rumination and depression.

Variables		***β***	***SE***	**t**
Mediator—depression				
Predictor: psychological strain		0.37	0.04	9.44 ***
Moderator: resilient coping		−0.11	0.03	−3.22 ***
Interaction: psychological strain x resilient coping		−0.07	0.03	−2.31 *
Outcome—suicide rumination				
Predictor: psychological strain		0.21	0.05	4.07 ***
Mediator: depression		0.45	0.05	8.28 ***
Moderator: perceived social support		−0.11	0.03	−3.25 **
Interaction: depression x perceived social support		−0.10	0.04	−2.94 **
R^2		0.31		
Different resilient coping values		*β*	*SE*	95% CI
	−1 *SD*	0.44	0.05	[0.344, 0.536]
	Mean	0.37	0.04	[0.290, 0.542]
	+1 *SD*	0.29	0.05	[0.191, 0.394]
Different perceived social support values		*β*	*SE*	95% CI
	−1 *SD*	0.57	0.07	[0.444, 0.708]
	Mean	0.45	0.05	[0.341, 0.554]
	+1 *SD*	0.32	0.07	[0.179, 0.460]

Note. CI = Confidence Interval; SE = Standard Error; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

For RQ4, whether PSS moderates the second stage of the mediator in the relationship between psychological strain and suicidal rumination was examined. As seen in Table 2 and Figure 3, there is a moderating effect of PSS on the effect of depression on suicidal rumination. The association of depression with suicidal rumination was stronger among individuals with low levels of PSS ($\beta = 0.57$, $SE = 0.07$, 95% CI = [0.4439, 0.7078]) than

among individuals with high levels of PSS (β = 0.32, *SE* = 0.07, 95% CI = [0.1786, 0.4603]). However, the indirect association of psychological strain via depression with suicide rumination was stronger among individuals with low levels of PSS (β = 0.23, *SE* = 0.05, 95% CI = [0.1286, 0.3398]) than among individuals with high levels of PSS (β = 0.13, *SE* = 0.03, 95% CI = [0.0625, 0.1990]).

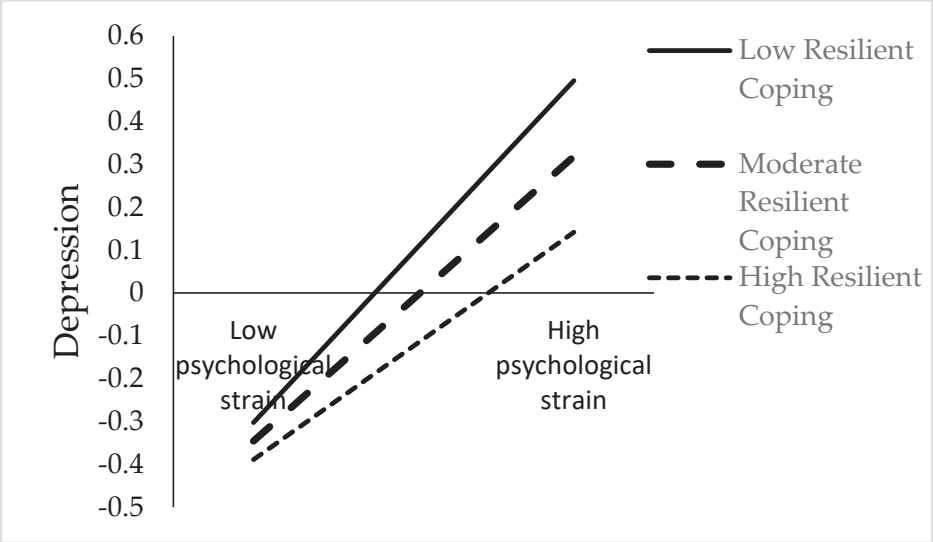

Figure 2. Interaction between psychological strain and resilient coping on depression.

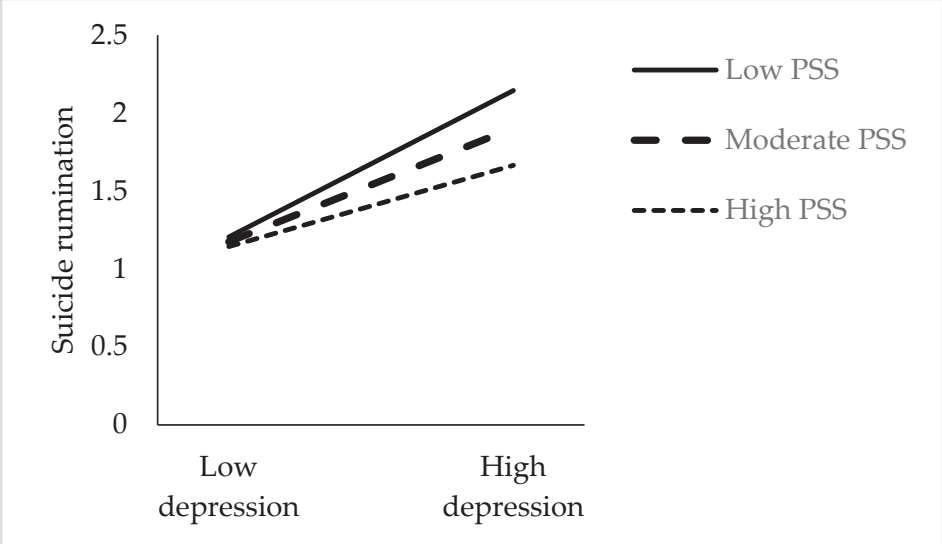

Figure 3. Interaction between depression and perceived social support (PSS) on suicide rumination.

4. Discussion

This study examined the complex relationships between psychological strain and suicide rumination. Previous studies have shown that suicidal ideation [56,57], suicidal intent [58], and suicidal behavior [59] are associated with psychological strain. However, no previous studies have been found that examine the relationship between psychological strain and suicide rumination and the possible psychological variables that may affect this relationship. Considering this gap in the literature, the present study aims to examine the mediating role of depression and the moderating role of resilient coping and perceived social support in the relationship between psychological strain and suicide rumination. The results confirmed the direct and indirect effects of psychological strain on suicide

rumination. The findings showed that depression mediated the relationship between psychological strain and suicide rumination, and resilient coping and perceived social support had a moderating role in this indirect relationship. In addition, the present study showed that the Strain Theory of Suicide can be used to explain suicide rumination in Turkish youth who continue their university education.

The psychometric properties of the DASS-8 and F-SozU K-3 scales were tested in the Turkish population. The EFA results for the construct validity of the DASS-8 scale showed that the scale comprises a three-factor structure in the Turkish population, similar to the results of previous studies. According to the EFA results for the F-SozU K-3, the scale consists of a single dimension, which is consistent with the previous study [48]. Then, a separate CFA was applied for both scales, and it was determined that the fit index values of DASS-8 were above the acceptance limits, while the F-SozU K-3 had excellent fit index values [49–51]. The goodness of fit values of both scales are similar to previous studies [45,48,60]. In the current study, the convergent and discriminant validity of the scales were also examined. The CR and AVE values [61,62] of DASS-8, the significant relationship between the DASS-8 total score and SRS and depression, anxiety, and stress confirm the convergent validity of the scale. Similarly, the CR and AVE values [61,62] of the F-SozU K-3 and the significant relationship between the scale and BRCS and SRS scores confirm the convergent validity. In addition, the significant correlation of both scales with depression, anxiety, and stress, which is less than 0.85, confirms the discriminant validity of the scale [50]. The internal consistency coefficients of both scales are consistent with the results of previous studies [48,60], and the results show that the scales are reliable. In summary, the results show that the DASS-8 and F-SozU K-3 are valid and reliable measurement tools in the Turkish university student population.

Whether psychological strain predicts suicide rumination in RQ1 has been tested. The findings showed that psychological strain significantly predicted suicide rumination in a positive direction. This finding indicates that Turkish university students who experience psychological strain may have difficulty in reaching a solution, and repetitive thoughts about ending their lives may increase. This finding is consistent with the results of previous studies [22,56,57]. There are also studies in the literature reporting that rumination increases in individuals who experience stressful life events [63]. Psychological strain involves both internal conflicts and strain that require resolution, as well as inadequate coping mechanisms [16]. Furthermore, university students are a population that has to deal with many developmental tasks [64], challenging peer relationships [65], and academic [66] and financial stress [65,67]. Intense strain felt in the face of different problem areas and inadequate coping mechanisms can hinder students' ability to make healthy cognitive assessments and produce effective solutions. Individuals who are unable to achieve internal balance may feel trapped and develop mental obsessions with repetitive suicidal thoughts (suicide rumination), considering suicide as a solution. However, this finding was obtained with the total score of psychological strain. Some university students may not experience psychological strain in all four areas, and the areas where they do experience psychological strain may vary. Therefore, a future, more detailed investigation of the effects of psychological strain sources on suicide rumination will contribute to the expansion of knowledge on this subject.

For RQ2, whether depression would mediate the relationship between psychological strain and suicide rumination was tested. As expected, the findings showed that psychological strain has an indirect effect on suicide rumination through depression. In this case, it can be said that depression explains psychological strain leading to suicide rumination among Turkish university students. This finding is in accordance with studies reporting that depression increases as the level of psychological strain increases [68,69] and that

individuals with depression have more suicidal thoughts [70]. Psychological strain may be accompanied by feelings such as frustration, hopelessness, and helplessness [16]. Challenging emotions experienced with psychological strain and decreased emotional resilience [69] may trigger depression. Depression may lead to increased suicide rumination because it reduces positive emotions [71], increases rumination, and reduces the use of functional and flexible emotion regulation strategies [72]. In addition, the current research finding supports previous research results showing that depression mediates the association between psychological strain and suicidal ideation in various populations [22,57]. Negative emotions that arise with psychological strain may deepen with depression. In the face of intense, challenging emotions, an individual's emotion regulation mechanism may become dysfunctional. This situation may negatively affect the well-being of university students and increase the tendency of repetitive thinking about suicide. Although the current study provides explanatory information about the role of depression in the relationship between psychological strain and suicide rumination, this relationship was examined in a one-way manner because a cross-sectional design was used in the study. These variables have a dynamic structure and interact with each other. Future research using a longitudinal design may provide deeper insights into the relationship between variables and change over time.

Findings showed that resilient coping moderated the relationship between psychological strain and depression. This finding supports recent research reporting significant negative associations between resilient coping and depression [73,74]. In addition, it is reported in the literature that those with high levels of resilient coping experience less psychological strain [75]; indeed, one of the four sources of psychological strain is inadequate coping [16]. Therefore, individuals with high resilient coping skills may experience psychological strain in fewer areas. In addition, when these individuals experience psychological strain, they can make active efforts to make progress by using their own resources and resort to new ways for solutions [46]. Making an effort and the search for new solutions, which develop due to resilient coping, can make individuals feel more hopeful [76]. Individuals with high levels of hope experience fewer depressive feelings and thoughts [77]. In conclusion, these relationships support the buffering role of resilient coping in the effect of psychological strain on depression. For this reason, intervention programs could be developed that aim to develop resilient coping skills, especially in university students experiencing psychological strain.

Finally, this study showed that perceived social support has a moderating effect on the relationship between depression and suicide rumination. In other words, higher levels of perceived social support are associated with a reduced effect of depression on suicide rumination. This finding supports the results of studies reporting a negative significant relationship between depression and perceived social support [78] and demonstrating the protective function of perceived social support towards suicidal ideation [79]. When individuals with depressive symptoms have a high perception of social support, they can cognitively reappraise events [80,81] and use more flexible coping strategies [75]. This situation may reduce the level of depression by increasing the use of individuals' personal resources. A decrease in depression levels is characterized by positive cognitive and emotional changes, which may also reduce suicide rumination. In addition, social support contributes to the individual's sense of belonging to his/her wider environment, society, and the world—from his/her family to the world. Social support has an especially important place in Turkey, where collectivist cultural values are dominant [82]. Therefore, social support may decrease suicide rumination by increasing belongingness and decreasing feelings of loneliness in depressed Turkish university students. However, this finding does not provide detailed information about which sources the participants received social

support from and to meet which needs [83]. Future studies may contribute to the expansion of the literature on this subject by addressing these dimensions of the social support source.

The findings of the present study should be evaluated while considering its limitations. The first limitation of the study is that causal inferences cannot be made using the findings due to the study's cross-sectional design. Experimental and longitudinal studies can be planned in the future to overcome this limitation. The second limitation is that the study sample consists of university students in the Southeast region of Turkey. Therefore, the results of the study cannot be generalized to all university students or different age groups across Turkey. In the future, studies with participants from different regions and age groups [84] can be conducted, and the results can be analyzed comparatively. The third limitation of the study is that the proportion of female participants is higher than that of male participants. The convenience sampling method was used, and the volunteering of the participants was taken into account. Since females volunteered to participate in the study more than males in the accessible population, a sufficient balance could not be achieved in the female–male ratio. Similar to the current study, the inadequacy of male and female representation in different disciplines and research areas is a topic of discussion [85,86]. To address this point, researchers can examine the factors affecting volunteering in psychological research from a gender perspective. Another limitation is that the participants could not respond to the measurement tools under similar conditions because the research data were collected through an online platform. This situation may have increased the effect of external factors and affected participant responses. Finally, the data for this study were collected using self-report instruments. Therefore, the participants may have answered the scales in the direction of social desirability. This limitation can be overcome by using qualitative data collection methods such as observations and interviews in future studies.

5. Conclusions

The present study provides important findings that can be used to inform interventions aimed at preventing suicide among university students. In particular, mental health professionals, university administration units, and academicians can ensure that the results of this research are translated into practice through various planned studies. Considering that suicide rumination is one of the determining factors of lifelong suicide attempts [19], identifying university students experiencing psychological strain may be the first step of suicide prevention interventions that can be carried out at universities. In the next step, effective intervention programs can be implemented for students experiencing psychological strain. Preparing the content for these programs, approaches, and techniques can be used to reduce depression, strengthen resilient coping, and increase social support resources instead of focusing only on psychological strain. In addition, mental health professionals could use group therapy while providing services to university students who are experiencing psychological strain and undergoing depressive processes. In addition to reducing psychological strain and depression levels in group therapy processes, students may find the opportunity to gain resilient coping skills and get rid of their feelings of loneliness. Additionally, university administration units could aim to increase perceived social support by designing spaces and planning activities that will increase students' interactions with their peers and professors. Academics, on the other hand, could plan activities that can be done together with groups in classes and structure courses to strengthen interpersonal bonds. Furthermore, policymakers can act by taking into account the results of this study when determining public health policies. In this way, suicide can be prevented by increasing strategies for coping with psychological strain.

Author Contributions: Conceptualization, N.T., M.Ö. and S.D.; formal analysis, N.T., M.Ö. and S.D.; methodology, N.T., M.Ö. and S.D.; supervision, N.T., M.Ö. and S.D.; visualization, N.T., M.Ö. and S.D.; writing—original draft preparation, N.T., M.Ö. and S.D.; writing—review and editing, N.T., M.Ö. and S.D. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: This research was also approved by the Siirt University Ethics Committee (reference number 8241) on 9 January 2025. Prior to data collection, each participant was asked to read the form containing information about the study. In addition, each participant completed a written informed consent form.

Informed Consent Statement: Informed consent was obtained from all participants involved in this study.

Data Availability Statement: The data supporting this study's findings are available from the corresponding author upon reasonable request. The data were anonymized, ensuring that there was no breach of privacy. They will be shared in a manner that respects ethical protocols and data protection regulations. The dataset will be accessible only for academic purposes, and any use of the data will recognize the original study and maintain the confidentiality of the participants.

Acknowledgments: We are grateful to all the individuals who participated in this study.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

WHO	World Health Organization
RQ	Research Questions
STS	Strain Theory of Suicide
PSS-SF	Psychological Strain Scales-Short Form
SRS	Suicide Rumination Scale
DASS-8	Depression Anxiety Stress Scale 8
BRCS	Brief Resilient Coping Scale
F-SozU K-3	Perceived Social Support Questionnaire
PSS	Perceived social support
CI	Confidence interval

References

1. World Health Organization [WHO]. *Suicide: One Person Dies Every 40 Seconds*; World Health Organization: Geneva, Switzerland, 2021. Available online: https://www.who.int/health-topics/suicide#tab=tab_1 (accessed on 12 November 2024).
2. World Health Organization [WHO]. *Depression and Other Common Mental Disorders: Global Health Estimates*; World Health Organization: Geneva, Switzerland, 2017. Available online: https://iris.who.int/handle/10665/254610 (accessed on 12 November 2024).
3. Cerel, J.; Brown, M.M.; Maple, M.; Singleton, M.; Van de Venne, J.; Moore, M.; Flaherty, C. How many people are exposed to suicide? Not six. *Suicide Life-Threat. Behav.* **2019**, *49*, 529–534. [CrossRef]
4. O'Connor, R. *When It Is Darkest: Why People Die by Suicide and What We Can Do to Prevent It*; Random House: New York, NY, USA, 2021.
5. Santos, H.G.B.D.; Marcon, S.R.; Espinosa, M.M.; Baptista, M.N.; Paulo, P.M.C.D. Factores asociados a la presencia de ideación suicida entre universitarios. *Rev. Lat.-Am. Enferm.* **2017**, *25*, e2878.
6. Karkın, A.N.; Eskin, M. Prevalence, correlates, and risk factors of suicidal ideation and attempts in Turkey. *Neuropsychiatr. Investig.* **2023**, *61*, 19–36. [CrossRef]
7. Robbins, A.; Wilner, A. *Quarterlife Crisis: The Unique Challenges of Life in Your Twenties*; Penguin: London, UK, 2001.
8. Moraes, S.M.A.B.; Barbosa, V.F.B.; Alexandre, A.C.S.; Santos, S.C.D.; Guimarães, F.J.; Veras, J.L.D.A. Risk of suicide among nursing students. *Rev. Bras. Enferm.* **2021**, *74*, e20200867. [CrossRef]

9. Arslan, G.; Türk, N.; Kaya, A. Psychological vulnerability, emotional problems, and quality-of-life: Validation of the brief suicide cognitions scale for Turkish college students. *Curr. Psychol.* **2024**, *43*, 21009–21018. [CrossRef]
10. Türk, N.; Yasdiman, M.B.; Kaya, A. Defeat, entrapment and suicidal ideation in a Turkish community sample of young adults: An examination of the Integrated Motivational-Volitional (IMV) model of suicidal behaviour. *Int. Rev. Psychiatry* **2024**, *36*, 326–339. [CrossRef] [PubMed]
11. Franklin, J.C.; Ribeiro, J.C.; Fox, J.D.; Bentley, K.R.; Kleiman, K.H.; Huang, E.M.; Musacchio, X.; Jaroszewski, K.M.; Chang, A.C.; Nock, B.P.; et al. Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychol. Bull.* **2017**, *143*, 187. [CrossRef]
12. Soper, C.A.; Malo Ocejo, P.; Large, M.M. On the randomness of suicide: An evolutionary, clinical call to transcend suicide risk assessment. In *Evolutionary Psychiatry: Evolutionary Perspectives on Mental Health*; Abed, R., St John-Smith, P., Eds.; Cambridge University Press and Royal College of Psychiatrists: Cambridge, UK, 2022; pp. 134–152. [CrossRef]
13. Yöyen, E.; Keleş, M. First-and second-generation psychological theories of suicidal behaviour. *Behav. Sci.* **2024**, *14*, 710. [CrossRef]
14. Zhang, J. From psychological strain to disconnectedness. *Crisis* **2016**, *37*, 169–175. [CrossRef] [PubMed]
15. Zhang, J.; Wang, W.; Huen, J.M.Y.; Lyu, J.; Lew, B. Towards higher psychometric properties: Testing the psychological strain scales with larger samples. *Arch. Suicide Res.* **2022**, *26*, 912–927. [CrossRef]
16. Zhang, J. The strain theory of suicide. *J. Pac. Rim Psychol.* **2019**, *13*, e27. [CrossRef]
17. Zhang, J.; Liu, Y.; Sun, L. Psychological strain and suicidal ideation: A comparison between Chinese and college students. *Psychiatry Res.* **2017**, *255*, 256–262. [CrossRef]
18. Rogers, M.L.; Law, K.C.; Houtsma, C.; Tucker, R.P.; Anestis, M.D.; Joiner, T.E. Development and initial validation of a scale assessing suicide-specific rumination: The suicide rumination scale. *Assessment* **2022**, *29*, 1777–1794. [CrossRef] [PubMed]
19. Rogers, M.L.; Joiner, T.E. Suicide-specific rumination relates to lifetime suicide attempts above and beyond a variety of other suicide risk factors. *J. Psychiatr. Res.* **2018**, *98*, 78–86. [CrossRef]
20. Erdem, M.; Akıncı, H.; Uyanık Negiz, Z. İntihar Ruminasyon Ölçeği'nin Türkçeye uyarlanması: Geçerlilik ve güvenirlilik çalışması. *Türk. Klin. Sağlık Bilim. Derg.* **2024**, *9*, 202–209.
21. Sahlan, R.N.; Grunewald, W.; Smith, A.R. Validations of the Farsi versions of the depressive symptom inventory suicidality subscale (F-DSI-SS) and suicide rumination scale (F-SRS) among Iranian college students. *Suicide Life-Threat. Behav.* **2023**, *53*, 16–28. [CrossRef]
22. Muneeb, N.U.A.; Hassan, S.M.U. Psychological strain and suicidal ideation in young university students during COVID-19 outbreak: The mediating roles of rumination and depression. *Curr. Psychol.* **2023**, *42*, 23731–23742. [CrossRef]
23. Demenech, L.M.; Oliveira, A.T.; Neiva-Silva, L.; Dumith, S.C. Prevalence of anxiety, depression and suicidal behaviors among Brazilian undergraduate students: A systematic review and meta-analysis. *J. Affect. Disord.* **2021**, *282*, 147–159. [CrossRef]
24. Sheldon, E.; Simmonds-Buckley, M.; Bone, C.; Mascarenhas, T.; Chan, N.; Wincott, M.; Gleeson, H.; Sow, K.; Hind, D.; Barkham, M. Prevalence and risk factors for mental health problems in university undergraduate students: A systematic review with meta-analysis. *J. Affect. Disord.* **2021**, *287*, 282–292. [CrossRef]
25. Zhang, J.; Lyu, J. Reliability, validity and preliminary hypothesis tests for the English version of the Psychological Strain Scales (PSS). *J. Affect. Disord.* **2014**, *164*, 69–75. [CrossRef] [PubMed]
26. Etemadi, Z.; Abbaspour, S.; Tirgari, A.; Bagian Koulemarzi, M.J. The mediating role of depression and hopelessness in the relationship of psychological strain, rejection sensitivity, and defeat with suicide ideation in adolescents in Iran. *Iran. J. Psychiatry Clin. Psychol.* **2023**, *29*, 170–187. [CrossRef]
27. Cano-López, J.B.; García-Sancho, E.; Fernández-Castilla, B.; Salguero, J.M. Empirical evidence of the metacognitive model of rumination and depression in clinical and nonclinical samples: A systematic review and meta-analysis. *Cogn. Ther. Res.* **2022**, *46*, 367–392. [CrossRef]
28. Soo, H.; Sherman, K.A. Rumination, psychological distress and post-traumatic growth in women diagnosed with breast cancer. *Psycho-Oncology* **2015**, *24*, 70–79. [CrossRef]
29. Nolen-Hoeksema, S.; Wisco, B.E.; Lyubomirsky, S. Rethinking rumination. *Perspect. Psychol. Sci.* **2008**, *3*, 400–424. [CrossRef]
30. Lamis, D.A.; Dvorak, R.D. Mindfulness, nonattachment, and suicide rumination in college students: The mediating role of depressive symptoms. *Mindfulness* **2014**, *5*, 487–496. [CrossRef]
31. Taugeer, A.; Eman, A.; Arif, L.; Bakhteyar, A.A.; Hassan, S.M.U. Coping Strain and Suicidal Ideation Among Pakistani adolescents: A moderated mediation model of depression and parental connectedness. *Pak. J. Psychol. Res.* **2024**, *39*, 851–873. [CrossRef]
32. Okechukwu, F.O.; Ogba, K.T.; Nwufo, J.I.; Ogba, M.O.; Onyekachi, B.N.; Nwanosike, C.I.; Onyishi, A.B. Academic stress and suicidal ideation: Moderating roles of coping style and resilience. *BMC Psychiatry* **2022**, *22*, 546. [CrossRef]
33. Gagay, V.V.; Alferova, E.I. Resilient coping as a personal resource for overcoming suicidal risk in older adolescents. *Russ. J. Educ. Psychol.* **2024**, *15*, 274–297. [CrossRef]

34. Sinclair, V.G.; Wallston, K.A. The development and psychometric evaluation of the Brief Resilient Coping Scale. *Assessment* **2004**, *11*, 94–101. [CrossRef] [PubMed]
35. Limonero, J.T.; Tomás-Sábado, J.; Fernández-Castro, J.; Gómez-Romero, M.J.; Ardilla-Herrero, A. Estrategias de afrontamiento resilientes y regulación emocional: Predictores de satisfacción con la vida [Resilient coping strategies and emotion regulation: Predictors of life satisfaction]. *Psicol. Conduct.* **2012**, *20*, 183–196.
36. Limonero, J.T.; Tomás-Sábado, J.; Gómez-Romero, M.J.; Maté-Méndez, J.; Sinclair, V.G.; Wallston, K.A.; Gómez-Benito, J. Evidence for validity of the Brief Resilient Coping Scale in a young Spanish sample. *Span. J. Psychol.* **2014**, *17*, e34. [CrossRef]
37. Otten, D.; Ernst, M.; Tibubos, A.N.; Brähler, E.; Fleischer, T.; Schomerus, G.; Wild, P.S.; Zöller, D.; Binder, H.; Kruse, J.; et al. Does social support prevent suicidal ideation in women and men? Gender-sensitive analyses of an important protective factor within prospective community cohorts. *J. Affect. Disord.* **2022**, *306*, 157–166. [CrossRef]
38. Wang, W.; Zhang, J. Social support, psychological strain, and suicidality: Evidence from Chinese universities. *Psychol. Sch.* **2024**, *61*, 205–219. [CrossRef]
39. Liu, Y.; Zhang, N.; Bao, G.; Huang, Y.; Ji, B.; Wu, Y.; Liu, C.; Li, G. Predictors of depressive symptoms in college students: A systematic review and meta-analysis of cohort studies. *J. Affect. Disord.* **2019**, *244*, 196–208. [CrossRef]
40. Lamis, D.A.; Ballard, E.D.; May, A.M.; Dvorak, R.D. Depressive symptoms and suicidal ideation in college students: The mediating and moderating roles of hopelessness, alcohol problems, and social support. *J. Clin. Psychol.* **2016**, *72*, 919–932. [CrossRef] [PubMed]
41. Zhang, J.; Lu, J.; Zhao, S.; Lamis, D.A.; Li, N.; Kong, Y.; Jia, C.; Zhou, L.; Ma, Z. Developing the Psychological Strain Scales (PSS): Reliability, validity, and preliminary hypothesis tests. *Soc. Indic. Res.* **2014**, *115*, 337–361. [CrossRef]
42. Huen, J.M.Y.; Zhang, J.; Osman, A.; Lew, B.; Yip, P.S.F. Using contemporary psychometric methods to construct and validate scores on a short-form version of the Psychological Strain Scales. *J. Affect. Disord.* **2021**, *281*, 1–8. [CrossRef] [PubMed]
43. Özmen, M.; Yasdıman, M.; Türk, N. Psychological strain and suicide cognitions: Mediating effects of resilient coping, anxiety and stress. *BMC Psychol.* 2025, *in press*.
44. Özmen, M. Turkish adaptation of suicide rumination scale in adult population: Validity and reliability study. *Bingöl Univ. J. Inst. Soc. Sci.* **2024**, *28*, 131–140. [CrossRef]
45. Ali, A.M.; Alkhamees, A.A.; Hori, H.; Kim, Y.; Kunugi, H. The depression anxiety stress scale 21: Development and validation of the depression anxiety stress scale 8-item in psychiatric patients and the general public for easier mental health measurement in a post COVID-19 world. *Int. J. Environ. Res. Public Health* **2021**, *18*, 10142. [CrossRef] [PubMed]
46. Kocalevent, R.D.; Zenger, M.; Hinz, A.; Klapp, B.; Brähler, E. Resilient coping in the general population: Standardization of the brief resilient coping scale (BRCS). *Health Qual. Life Outcomes* **2017**, *15*, 251. [CrossRef] [PubMed]
47. Temsah, M.H.; Alenezi, S.; Alarabi, M.; Aljamaan, F.; Alhasan, K.; Assiri, R.; Bassrawi, R.; Alshahrani, F.; Alhaboob, A.; Alaraj, A.; et al. Healthcare workers' SARS-CoV-2 omicron variant uncertainty-related stress, resilience, and coping strategies during the first week of the World Health Organization's alert. *Int. J. Environ. Res. Public Health* **2022**, *19*, 1944. [CrossRef] [PubMed]
48. Petersen, J.; Reinwarth, A.C.; Beutel, M.E.; Brähler, E.; Decker, O. Development and validation of a brief three-item form of the perceived social support questionnaire (F-SozU K-3). *Int. J. Clin. Health Psychol.* **2024**, *24*, 100496. [CrossRef] [PubMed]
49. Hu, L.T.; Bentler, P.M. Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Struct. Equ. Model.* **1999**, *6*, 1–55. [CrossRef]
50. Kline, R.B. *Principles and Practice of Structural Equation Modeling*; Guilford Publications: New York, NY, USA, 2015.
51. van de Schoot, R.; Lugtig, P.; Hox, J. A checklist for testing measurement invariance. *Eur. J. Dev. Psychol.* **2012**, *9*, 486–492. [CrossRef]
52. Hancock, G.R.; Mueller, R.O. *The Reviewer's Guide to Quantitative Methods in the Social Sciences*; Routledge: New York, NY, USA, 2010.
53. Hayes, A.F. *Introduction to Mediation, Moderation, and Conditional Process Analysis: A Regression-Based Approach*; Guilford Press: New York, NY, USA, 2013.
54. Preacher, K.J.; Hayes, A.F. Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. *Behav. Res. Methods* **2008**, *40*, 879–891. [CrossRef]
55. Brislin, R.W.; Lonner, W.J.; Thorndike, R.M. *Cross-Cultural Research Methods*; John Wiley & Sons: Hoboken, NJ, USA, 1973.
56. Moosivand, M.; Bagian Kulemarzi, M.J.; Zaremohzzabieh, Z.; Zarean, M.; Rajabi, M.; Khanjani, S. The structural model of the effects of psychological strain, defeat, and thwarted belongingness on suicidal ideation in adolescents via the mediation of depression and hopelessness. *Arch. Suicide Res.* **2024**, *28*, 1077–1092. [CrossRef]
57. Sun, G.; Zhao, J.; Tian, S.; Zhang, L.; Jia, C. Psychological strain and suicidal ideation in athletes: The multiple mediating effects of hopelessness and depression. *Int. J. Environ. Res. Public Health* **2020**, *17*, 8087. [CrossRef]
58. Sun, L.; Zhang, J. Psychological strains and suicidal intent: An empirical study to relate the two psychopathological variables. *J. Nerv. Ment. Dis.* **2016**, *204*, 855–860. [CrossRef]

59. Sun, L.; Li, H.; Zhang, J.; Wu, Q. Psychological strains and suicide intent: Results from a psychological autopsy study with Chinese rural young suicides. *Int. J. Soc. Psychiatry* **2015**, *61*, 677–683. [CrossRef] [PubMed]
60. Ali, A.M.; Hori, H.; Kim, Y.; Kunugi, H. The Depression Anxiety Stress Scale 8-items expresses robust psychometric properties as an ideal shorter version of the Depression Anxiety Stress Scale 21 among healthy respondents from three continents. *Front. Psychol.* **2022**, *13*, 799769. [CrossRef]
61. Fornell, C.; Larcker, D.F. Evaluating structural equation models with unobservable variables and measurement error. *J. Mark. Res.* **1981**, *18*, 39–50. [CrossRef]
62. Shrestha, N. Factor analysis as a tool for survey analysis. *Am. J. Appl. Math. Stat.* **2021**, *9*, 4–11. [CrossRef]
63. Michl, L.C.; McLaughlin, K.A.; Shepherd, K.; Nolen-Hoeksema, S. Rumination as a mechanism linking stressful life events to symptoms of depression and anxiety: Longitudinal evidence in early adolescents and adults. *J. Abnorm. Psychol.* **2013**, *122*, 339–352. [CrossRef] [PubMed]
64. Arnett, J.J. Emerging adulthood: What is it, and what is it good for? *Child Dev. Perspect.* **2007**, *1*, 68–73. [CrossRef]
65. Moore, A.; Nguyen, A.; Rivas, S.; Bany-Mohammed, A.; Majeika, J.; Martinez, L.A. qualitative examination of the impacts of financial stress on college students' well-being: Insights from a large, private institution. *SAGE Open Med.* **2021**, *9*, 20503121211018122. [CrossRef]
66. Barbayannis, G.; Bandari, M.; Zheng, X.; Baquerizo, H.; Pecor, K.W.; Ming, X. Academic stress and mental well-being in college students: Correlations, affected groups, and COVID-19. *Front. Psychol.* **2022**, *13*, 886344. [CrossRef] [PubMed]
67. Nasr, R.; Rahman, A.A.; Haddad, C.; Nasr, N.; Karam, J.; Hayek, J.; Ismael, I.; Swaidan, E.; Salameh, P.; Alami, N. The impact of financial stress on student wellbeing in Lebanese higher education. *BMC Public Health* **2024**, *24*, 1809. [CrossRef]
68. Zhang, J.; Lv, J. Psychological strains and depression in Chinese rural populations. *Psychol. Health Med.* **2014**, *19*, 365–373. [CrossRef]
69. Zhang, J.; Huen, J.M.Y.; Lew, B.; Chistopolskaya, K.; Abu Talib, M.; Siau, C.S.; Leung, A.N.M. Depression, anxiety, and stress as a function of psychological strains: Towards an etiological theory of mood disorders and psychopathologies. *J. Affect. Disord.* **2020**, *271*, 279–285. [CrossRef]
70. Ladi-Akinyemi, T.W.; Okpue, A.P.; Onigbinde, O.A.; Okafor, I.P.; Akodu, B.; Odeyemi, K. Depression and suicidal ideation among undergraduates in state tertiary institutions in Lagos Nigeria. *PLoS ONE* **2023**, *18*, e0284955. [CrossRef] [PubMed]
71. Vanderlind, W.M.; Millgram, Y.; Baskin-Sommers, A.R.; Clark, M.S.; Joormann, J. Understanding positive emotion deficits in depression: From emotion preferences to emotion regulation. *Clin. Psychol. Rev.* **2020**, *76*, 101826. [CrossRef]
72. LeMoult, J.; Gotlib, I.H. Depression: A cognitive perspective. *Clin. Psychol. Rev.* **2019**, *69*, 51–66. [CrossRef]
73. Finch, B.; Ong, E. Exploring coping resiliency and depression among university students in a post-pandemic context. *Adv. Ment. Health* **2024**, *22*, 711–727. [CrossRef]
74. Laranjeira, C.; Dixe, M.A.; Valentim, O.; Charepe, Z.; Querido, A. Mental health and psychological impact during COVID-19 pandemic: An online survey of portuguese higher education students. *Int. J. Environ. Res. Public Health* **2022**, *19*, 337. [CrossRef]
75. Sharp, P.; Oliffe, J.L.; Kealy, D.; Rice, S.M.; Seidler, Z.E.; Ogrodniczuk, J.S. Social support buffers young men's resilient coping to psychological distress. *Early Interv. Psychiatry* **2023**, *17*, 784–791. [CrossRef]
76. Batmaz, H.; Türk, N.; Doğrusever, C. The mediating role of hope and loneliness in the relationship between meaningful life and psychological resilience in the COVID-19 Pandemic during. *Anemon Muş Alparslan Üniv. Sos. Bilim. Derg.* **2021**, *9*, 1403–1420. [CrossRef]
77. Ai, A.L.; Li, W.; Lemieux, C.M. When state rescuing systems were paralyzed: Post-hurricane depression, hope, and spirituality of Black and White student volunteers. *J. Am. Coll. Health* **2025**. [CrossRef] [PubMed]
78. Cheng, J.; Zhao, Y.Y.; Wang, J.; Sun, Y.H. Academic burnout and depression of Chinese medical students in the pre-clinical years: The buffering hypothesis of resilience and social support. *Psychol. Health Med.* **2020**, *25*, 1094–1105. [CrossRef] [PubMed]
79. Thomas, A.L.; Brausch, A.M. Family and peer support moderates the relationship between distress tolerance and suicide risk in black college students. *J. Am. Coll. Health* **2022**, *70*, 1138–1145. [CrossRef]
80. Gupta, S.; Fischer, J.; Roy, S.; Bhattacharyya, A. Emotional regulation and suicidal ideation—Mediating roles of perceived social support and avoidant coping. *Front. Psychol.* **2024**, *15*, 1377355. [CrossRef]
81. Li, N.; Cheng, H.; Li, S.; Lv, L. The influences of social support and emotion regulation strategies on posttraumatic growth of burn survivors: A cross-sectional study in Linyi, China. *Nurs. Health Sci.* **2023**, *25*, 89–97. [CrossRef] [PubMed]
82. Selcuk, B.; Brink, K.A.; Ekerim, M.; Wellman, H.M. Sequence of Theory of Mind acquisition in Turkish children from diverse social backgrounds. *Infant Child Dev.* **2018**, *27*, e2098. [CrossRef]
83. Zimet, G.D.; Powell, S.S.; Farley, G.K.; Werkman, S.; Berkoff, K.A. Psychometric characteristics of the multidimensional scale of perceived social support. *J. Personal. Assess.* **1990**, *55*, 610–617. [CrossRef]
84. Türk, N.; Arslan, G.; Kaya, A.; Güç, E.; Turan, M.E. Psychological maltreatment, meaning-centered coping, psychological flexibility, and suicide cognitions: A moderated mediation model. *Child Abus. Negl.* **2024**, *152*, 106735. [CrossRef]

85. Borg, D.J.; Haritopoulou-Sinanidou, M.; Gabrovska, P.; Tseng, H.W.; Honevman, D.; Schweitzer, D.; Rae, K.M. Barriers and facilitators for recruiting and retaining male participants into longitudinal health research: A systematic review. *BMC Med. Res. Methodol.* **2024**, *24*, 46. [CrossRef] [PubMed]
86. Smith, E.S.; McKay, A.K.A.; Kuikman, M.; Ackerman, K.E.; Harris, R.; Elliott-Sale, K.J.; Stellingwerff, T.; Burke, L.M. Auditing the representation of female versus male athletes in sports science and sports medicine research: Evidence-based performance supplements. *Nutrients* **2022**, *14*, 953. [CrossRef] [PubMed]

healthcare

MDPI

Article

Suicide and Self-Harming Among Young Women: A Qualitative Exploratory Study in Southern Punjab, Pakistan

Farooq Ahmed [1,*], Eileen Yuk Ha Tsang [2,*], Razia Anjum [3], Najma Iqbal Malik [4], Sidra Zia [1], Rashed Nawaz [5], Jeffrey S. Wilkinson [6] and Yueyao Fang [2]

1 Department of Anthropology, The Islamia University of Bahawalpur, Bahawalpur 63100, Pakistan; sidrazia2010@hotmail.com
2 Department of Social and Behavioral Sciences, City University of Hong Kong, Hong Kong 852, China; yueyafang2-c@my.cityu.edu.hk
3 Department of Psychology, Bath Spa University, Ras al Khaimah 71705, United Arab Emirates; razia@bathspa.ae
4 Department of Psychology, University of Sargodha, Sargodha 33600, Pakistan; najma.iqbal@uos.edu.pk
5 School of Public Health and Health Nutrition, Luohe Medical College, No.148, Daxue Road, Yuanhui District, Luohe 462002, China; rashednawazpk@gmail.com
6 School of Journalism and Graphic Communication, Florida A&M University, Tallahassee, FL 32311, USA; jeffrey.wilkinson@famu.edu
* Correspondence: farooq.ahmed@iub.edu.pk (F.A.); eileen@cityu.edu.hk (E.Y.H.T.)

Abstract: Background: Suicide and self-injury are serious public health concerns, especially in young populations, owing to multiple social, cultural, and gender determinants. Qualitative evidence exploring narratives regarding the factors behind suicide among young women is rare in Pakistan. Objective: The present study aims to explore the complex dimensions of suicide or self-injury among young women of Southern Punjab. Methods: Semi-structured interviews were conducted in a marginalized district in South Punjab, with participants consenting to in-person meetings at their homes or phone interviews. We collected detailed accounts of fifteen deceased girls or self-harm survivors, with insights provided by close relatives of the victims. Results: Our findings identified several conducive factors to suicidality, including receiving insults in front of others, low self-esteem, household pressures, work burdens, unfulfilled romantic desires, feelings of worthlessness, cheating in love, marriage without choice, and engagement in risky behaviors. These causes could be categorized into personal (such as an inferiority complex), social (a lack of family support and frequent conflicts), and cultural factors (forced marriages). Conclusions: Our study advocates for empowering women through education and restricting access to suicide means, such as pesticides or Paraphenylenediamine (PPD). Moreover, the government should take strict measures to discourage the forced marriage of young females in rural contexts. This study highlights the importance of integrating suicide prevention initiatives with research efforts within Pakistan's healthcare system.

Keywords: suicidality; rural women; marriage; Paraphenylenediamine (PPD); Southern Pakistan; thematic analysis

1. Introduction

Suicide is a major global health issue, particularly among individuals aged 15–30, with over 800,000 deaths annually [1,2]. It is a leading cause of mortality in several low- and middle-income countries (LMICs), with nearly 45% of global suicides occurring in just two countries: China and India. In China, the suicide rate is notably higher in rural areas compared to urban regions.

The accurate reporting of suicides to the police, health systems, and the WHO is often hindered by the potential legal and social repercussions faced by the victims' families. Official mortality data on suicide at the national level in Pakistan are unreliable because family members often attribute suicide to "accidental" deaths or "natural death". However, the WHO's estimates show a suicide rate of 7.5 per 100,000 individuals, a 2.6% rise since 2000, with approximately 270,000 annual cases of deliberate self-harm (DSH) [1]. The WHO prioritizes the elimination of suicidal acts through initiatives such as the Mental Health Gap Action Program (MHGAP), and preventing suicide is included in its sustainable development goals [3].

Suicide is defined as a fatal self-inflicted act with clear evidence of an intent to die [4]. Around 80% of all suicides occur in LMICs [5]. In 2015, the global suicide rate was 10.7 per 100,000 people, equating to approximately one death every 20 s. Suicide represents 1.4% of all deaths and ranks as the 15th leading cause of death worldwide [3,5]. In LMICs, the suicide rate among women is very high [6]. Evidence indicates that women's suicidality is higher in Asian countries such as China, India, Pakistan, and Nepal [7].

In general, suicidal behavior is correlated with conflict, tragedy, violence, abuse, loss, and a sense of isolation [1]. Both self-harm and suicide are prohibited and considered illegal under Islam and the law of the country. Self-harm or suicide is viewed as a sin in Islam. In Islam, suicide is deemed an illegitimate act, and those who commit suicide are believed to be denied entry into paradise [8]. Legally, suicide is a violation and is classified as a violent crime. For a suicide attempt, Section 325 of the Pakistan Penal Code (PPC) mandates penalties of up to one year's imprisonment, fines, or both [9]. As per law, suspected suicide or self-harm cases ought to be reported to selected medicolegal centers (MLCs). However, to avoid legal repercussions, family members usually request initial treatment at private hospitals, often discharging themselves against medical advice due to the fear of prosecution, financial limitations, and societal shame. Suicidal behavior is under-reported due to these challenges in Pakistan.

The World Health Organization (WHO) aims to enhance the public understanding of the health impacts of suicide and self-harm while also assisting countries in developing and strengthening comprehensive, multisectoral strategies for suicide prevention within a public health framework [3]. Suicide often goes unrecognized or unreported due to its sensitive nature and the ongoing taboo surrounding it [10]. The risk of suicide is linked to traumatic events and environmental changes [11,12].

Lester's work, *Why Women Kill Themselves*, is a comprehensive, cross-disciplinary collection that includes several insightful sections on the psychological mechanisms associated with suicide and the spiritual themes found in women's suicide notes [13]. However, the collection has its shortcomings as it highlights a prevalent tendency among researchers to examine women's suicide with their biology, particularly their reproductive cycles. It is noteworthy that between 1999 and 2012, the increase in the suicide rate among women in Northern Ireland was slightly higher than that among men [14], yet their deaths received minimal attention. For example, suicide in women is rarely covered in the media, and even more concerning is that women often go unrecognized in suicide prevention policies [15]. Research has explored how social factors, life events, and aspects of female identity may be linked to the deaths of women who died by suicide [16].

Only few previous qualitative studies showed that an early age of marriage, the lack of independence in the choice of the male partner (arranged marriage customs), pressure to have children early in the marriage, the desire for a male offspring, economic dependence on husband, a joint or extended family system, and domestic violence are critical sociocultural factors that determine women's health. There is little evidence that shows that gender is an important determinant of suicide and self-harm in Pakistan, especially when considered in

the context of marital status among young rural women. There is a dearth of qualitative studies that focus on social and cultural determinants of women's suicide; therefore, the present study explores the causes of suicide and self-injury among young rural women from South Punjab.

2. Methodology

2.1. Background and Study Setting

In this study, we investigate suicide among young rural women of Southern Punjab regions, examining reports of suicide and self-harm, their current mental health status, and their future intentions regarding suicide. Pakistan, a country with a population of 220 million, comprises four provinces (Punjab, Sindh, Baluchistan, and Khyber Pakhtunkhwa) with various languages and cultural norms. Southern parts of the country are marginalized, including the Southern Punjab districts in Punjab province. South Punjab is a highly disadvantaged region that lacks adequate hospitals, psychiatrists, and clinicians. In southern districts, young people are deprived of essential services such as healthcare, education, safe drinking water, food, and sanitation, and children suffer from diarrhea and malnutrition. Rural areas in South Punjab are marginalized with limited health facilities, particularly for women, who face significant barriers to accessing healthcare, resulting in missed opportunities for better health [6,17]. Contraception prevalence is low, and women have to experience high fertility and low birth spacing. Poverty is widespread, and communities often face moderate to severe water and food insecurity experiences [18]. Household male members have to migrate to Gulf countries as manual labor for their survival and subsistence, while women have to work as domestic household servants [19,20]. Many poor females suffer from domestic and gender-based violence and insulting behaviors from their in-laws after marriage due to their unemployment, poverty, and low education level [21–23].

2.2. Participants

2.2.1. Sampling and Inclusion/Exclusion Criteria

This qualitative study is based on a purposive selection of victims' relatives, siblings, neighbors, and teachers from the South Punjab region of Pakistan. The respondents in this research were identified through close connections, who were engaged to explore the circumstances that led them to believe there is no way out. We also discovered what methods and means they used to harm themselves and the impact on their health.

This study specifically included participants who recently had lost a close young female sibling, relative, or friend. Only young and rural women between 18 and 25 from the most marginalized districts of South Punjab, who have committed or survived suicide attempts, were eligible to be included. In total, fifteen respondents showed willingness to participate in this study and provided their verbal consent. In the final round, nearly thirteen cases of young women between the ages of 18 and 25 years could be narrated. Most of our study involved cases of victims who died after suicide attempts, while a few cases were those who self-injured.

2.2.2. Interviews and Data Collection Procedure

The data were collected through semi-structured interviews and analyzed through probing, exploratory scrutiny, fact-finding, and a comprehensive examination of the circumstances in which individuals feel trapped. We selected interview locations that made respondents feel safe and comfortable. The use of audio recorders was with their permission. Some participants did not allow recording; therefore, we took notes respecting the participants' traditional views and comfort levels. The interviews were conducted in a flexible format, lasting between one and two hours, and in the local (Seraiki) language. We

fostered a warm and inviting atmosphere during the interviews and asked participants about the motivation for committing suicide or self-injury. They were asked to narrate the important and relevant parts of the victim's life story. Participants were allowed to withdraw at any time without consequences. They were allowed to take a break if any difficult situation arose.

2.3. Thematic Analysis Procedure

Various steps were followed using Braun and Clarke's framework for a thematic analysis procedure [24]. Soon after data collection from consenting participants using purposive sampling, all thirteen semi-structured interviews and field notes were translated from the local language to English. Three authors (FA, SZ, and RA) familiarized themselves with the data through the repeated reading of transcripts. Subsequently, in the next stage, recorded interviews were transcribed, and a coding frame was developed. Two authors (FA and SZ) used Nvivo for line-by-line coding to identify meaningful units. Then, two authors (FA and NIM) grouped several codes into themes and edited them through iterative discussion. Finally, researchers cross-checked themes against raw data and detached discrepancies via consensus. Themes were organized based on the analyzed data using a qualitative interpretative approach. Using this systematic approach, we ensured rigor and transparency in originating insights from respondents' self-reported experiences. Thematic analysis provides a rigorous framework for in-depth qualitative exploration, allowing the systematic organization and interpretation of complex data. With participants' informed consent, we collected and analyzed self-reported experiences through semi-structured interviews, ensuring rich, detailed responses for evaluation. The themes and sub-themes are shown in the diagram (Figure 1).

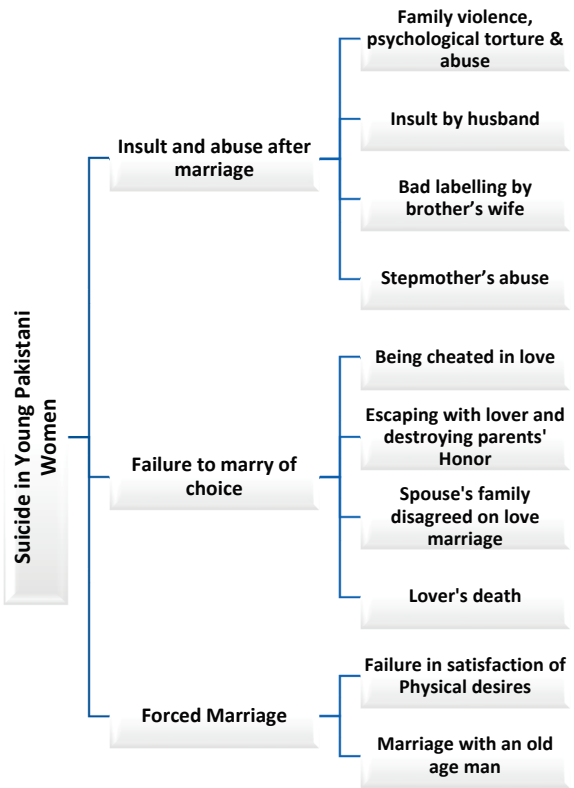

Figure 1. Suicidality among young women in Southern Pakistan.

2.4. Ethical Consideration

Department of Anthropology at the Islamia University of Bahawalpur granted ethical approval for this study (IUB/ANTH/99; date of approval 5 June 2024). Before participating in the study, all respondents were informed about its nature. Informed consent was taken from the respondents. Privacy, confidentiality, and anonymity were fully ensured. We did not disclose the real names of participants to protect their identities. Moreover, fictitious numbers were used to hide the original identity of the suicide and self-harm cases.

3. Results

Table 1 gives the sociodemographic characteristics of the study respondents. Most women were young, less educated, rural, and from a lower socioeconomic background. Many of them used poisonous substances to kill themselves, and marriage-related issues were behind the underlying determinants.

Table 1. Sociodemographic characteristics of victims, harm methods, and causes behind suicide and self-harm.

Case	Age in Years	Education	Household Income (PKR)	Harm Method	Immediate Cause Behind the Attempt	Underlying Cause
R9	18	Higher Secondary	20 K	Came under a train	Family violence, psychologically tortured, and abused	Insult
A2	21	Middle	21 K	Black Rock	Mentally tortured and badly labeled by his brother's wife	Insult
H11	20	Illiterate	10 K	Black Rock	Stepmother's abuse and insult	Insult
R12	16	Illiterate	12 K	Insecticide	Husband insulted (marital stress), psychologically tortured	Insult
T4	25	Illiterate	15 K	Organophosphorus (pesticides)	Husband insults in front of family members	Insult
T10	19	Secondary	25 K	Hanged	Boyfriend cheats on her	Love Marriage Failure infidelity
S13	24	Secondary	14 K	Black Rock	Escape with boyfriend, destroy parents' reputation (honor)	Love Marriage Failure
N1	20	Secondary	25 K	Insecticide	Spouse's family disagreed about love marriage	Love Marriage Failure
U7	20	Illiterate	50 K	Hanged	Violence and boyfriend's death	Love Marriage Failure
K3	20	Primary	13 K	Black rock	Exchange marriage does not satisfy desire	Forced Marriage
E6	19	Middle	15 K	Nail polish remover	Does not agree to marry an old man	Forced Marriage
B6	18	Higher Secondary	20 K	Firearm	Marriage	Arranged Marriage
A7	21	Middle	21 K	Hanging	Marriage without consent	Forced Marriage

3.1. Theme One: Forced Marriages or Marriage Without the Choice of Young Girls

Women are forced to marry according to the will of their parents, family members, and relatives. However, these exchange marriages do not guarantee fulfilling their emotional and sexual needs. Multiple times, the age factor in these marriages is not considered. Exchange marriages without consent often stop sexual needs from being satisfied and cause suicidal ideation among rural females.

3.1.1. Protest Against the Forced Marriage

Marriage with an aged person was the main cause, as one woman reported. Her old husband was unable to fulfill the sexual desire of her young wife. For this reason, the young bride was angry with her parents, but no one bothered to understand her feelings. On her first suicide attempt, some relatives arrived on time and carried her to the hospital, where her stomach was washed and her life was saved. After some time, she again attempted suicide but could not survive this time, and she passed away. One lady explained about her old uncle's exchange marriage (locally called watta-satta).

> *"My 70-year-old uncle got married by exchanging her son's daughter with the groom's brother. Once I asked, Are you happy with this old uncle? She said, 'he can't fulfill my desire. Wealth is not sufficient. Please ask my parents, "I can no longer live with him. Otherwise, I would take my life." 'Everyone was aware of her critical situation. One day, in the absence of my uncle, she attempted suicide, but one family member saved her life. She warned, 'If you don't divorce me, I will do it again.' But no one could take it seriously. After some time, she took a black rock and ate it with some juice. This time she succeeded in dying".*

Self-harm due to forced marriage is common. One respondent explained how a young girl in their family attempted suicide due to forced marriage:

> *"She did not agree to marry an old man and attempted suicide. When we reached, she had drunk all the nail-polish remover, and her family members were crying. Her stomach was bulging inside her belly, she was not breathing well. She was catching her neck. My husband brought her to the hospital. The doctor told her that her breathing pipe would be disturbed for her whole life".*

3.1.2. Cultural Violence as the Motivating Determinant of Suicide

Suicide was committed as a form of protest against cultural violence, as remarked by a woman.

> *"The future of women is decided without their consent, by the parents and family elders, and soon after marriages, domestic disputes and unsustainable relationships erupt with husbands, which forces women to commit suicide".*

A mother of a 25-year-old female suicide victim reported the following:

> *"My husband disliked that her daughter disobeyed his decision to marry. I failed to convince him, but he deemed his daughter's confrontation an abuse of the local norms and customs. This controversial marriage made her depressed. My well-educated daughter decided to kill herself soon after she was forced to marry her uneducated cousin. My husband was ready to withdraw from his stance, so our daughter thought it better to lose her life".*

The custom of honor killing is very relevant in the rural context of South Punjab. According to a mother, "kalakali" is the main issue for the increased suicide cases.

> *"Kalakali means when a married woman is caught with her boyfriend, the family honor is considered ruined. Women in that case often prefer to die otherwise, they are sold out or*

murdered. The reasons to commit suicide are many, but the main causes are misbehavior, domestic issues, and violence by husbands and relatives. We did not report the suicide case to the police and kept it secret to evade social stigma".

3.2. Theme Two: Insulting Behaviors of Relatives and Suicide Among Women

3.2.1. Violence, Stigma, and Depression

Several reasons were identified for suicide and self-harm: violence, stigmatization, mental torture and labeling, and the stepmother's abuse and insults. Insulting behavior from family members and in-laws is the leading reason for suicide in young women. One respondent discussed the suicide of her aunt:

"My aunt fell in love; her boyfriend sent his family to propose, but her parents refused, saying that since your elder sisters are still unmarried, how can you marry? After this, her family members used to abuse her verbally and physically. One day, she came in front of the train and was no more".

Embarrassed by her brother's and his wife's behavior, the 18-year-old girl heard that someone had died by suicide by eating kala pathar [PPD] with a glass of sweet juice. Abused by her brother's wife, she also prepared her mind to do the same. She went to the shop, bought and ate PPD with juice, and died by suicide. Her relatives called her again and again, but she was missing. Her younger brother's daughter went to the room where she was vomiting, but after some time, she was no more. Stigmatizing someone might be a risk factor.

One aunt talked about her niece's sudden death at a young age in the following words:

"My niece was young, energetic, and talented. Her brother's wife was strict and cruel; she treated her like a maid. Her mother was a social lady and often used to leave her alone in the house with her brother's wife. She was asked to wash clothes and utensils and cook food. Even after her work, her brother's wife was not happy and used to label, stigmatize, and abuse her all the time. One day, she bought a packet of henna with black rock (PPD) and ate it with juice. After some time, her brother's wife called her to make the loaf, but there was no answer. Her daughter went to check her in the room, but she was vomiting, and later she died".

Black rock is a hair-dyeing mixture with red henna. It is available in every local market, small shops, and even in food shops. Everyone can buy it very easily. It gives a very luminous color to hair, but it can kill within a few minutes if eaten.

The stepmother's violence and labeling were reported as the reason for her taking her life. One female told the story of her niece:

"My niece was a young, beautiful, and intelligent girl. But for some time, she was very disturbed and disappointed with her stepmother. She abused her in front of her dad, but her dad never interfered and supported. She came to me and was weeping and said, 'Aunt (father's sister), I will not go to my house because my stepmother pains me and labels me.' The next day, we heard that she had eaten the black rock, which she reportedly brought for dyeing the hair. The main reason was consistent mistreatment of her stepmom with her and often labeling her as a bad character woman".

3.2.2. Insult in Front of Other Family Members

Insult in front of family members strongly motivated suicide among women. One respondent who attempted suicide but was saved explained how her husband's insult caused suicidality:

"It was his habit to insult me before our children. One day, I told him, Now our children are older, please don't insult me in front of them." He replied, 'I don't care about you and

your children, leave me, I will never die without you.' I was shocked and went to the room, took the pesticide, and drank it. But later, I was saved by the doctors".

Women self-harmed when their self-respect was crushed. One lady elaborates as follows:

"My husband was bad-tempered and used to insult me in front of my family members. He often put me in a painful situation. Once, I saw a spray bottle of organophosphorus compounds (pesticides) in anger and drank a few sips. But my family members managed to take me to the hospital, and I was saved".

3.3. Theme Three: Failure in Marriage or Love Due to Unfaithfulness

3.3.1. Failing to Marry Due to Cheating

Failing to marry due to cheating is another major reason for suicide among women. Marriage reportedly failed owing to a range of factors, including cheating, refusing to marry the boyfriend, destroying the parents' reputation (honor), resistance from the spouse's family about a love marriage, and the boyfriend's death.

Quarrelling with a girlfriend was also highlighted as one of the potential causes. One lady elaborates on her sister's suicide case due to infidelity:

"My sister loved a boy, but when she insisted on marrying her, he shouted and said No, I have many girlfriends, and I can't marry all of them. You are not the only one with whom I talk. If you ask me to marry you, I will block your number from my contact list. And he literally did this. My sister was very sensitive; she could not accept this insult and hanged herself. After a few days, the police arrested him, and he agreed that they both quarreled".

Women commit suicide when they get cheated on and their family's reputation (honor) is spoiled. One girl elaborates on her classmate's suicide:

"My classmate from a very ethnically strict family fell in love. People told her not to meet with that guy. He belonged to a very rich family, maybe he will cheat you. She said, 'Love is blind. I cannot live without him. I know my parents are strict, but this love is not in my control, it's in my heart.' Once she escaped with that guy, but unfortunately, the boy left her. After some days, my classmate came to her parents' house, but they did not want to accept her. They said, 'You buried our honor, we wish you were buried under this earth.' She did not accept this treatment from her own parents and committed suicide with the black rock".

3.3.2. Failure of a Love Marriage

Failure of a love marriage can also trigger suicide among sensitive females. A girl narrated a story about her sister:

"She was young, beautiful, with long hair, but was looking sad. I tried to investigate what happened. She revealed: 'I think I will die soon because I often dream, I am dying. One night I dreamed that I died and there was a moringa tree upon my grave.' I said to her, Don't feel stressed, just donate some slaughter. It was just a dream. My sister fell in love with my cousin, but the boy's mom did not agree. One night, my sister used insecticide crushed tablets, which were used for the protection of wheat. In the early morning, she fainted and all family members wanted to save her life, but it was too late".

Marriage outside of the family is disliked. Many girls commit suicide when their families do not support their marriage. The death of a lover was mentioned as a strong reason for suicide. A teacher narrated the story of her student:

"One of my female students fell in love with someone, and the boy was from another caste. She discussed this matter with her brothers, who got angry when she discussed this

matter with them. They said, Go and marry, but we will give no piece of land to you. We will not allow them to become rebels like you. After some period, that girl came to me and told me, 'My love has died due to a medical issue, my brothers also don't accept me, now I have no reason to live, I want to die. After that, she hanged herself and died".

4. Discussion

In this study, we identified the causes of suicide among young rural females of South Punjab, Pakistan. The primary factors contributing to suicide include poverty, insufficient family support, violence, insult, fear, conflicts within marital life, and forced marriages. According to Agnew's General Strain Theory (GST) [25], there are three primary functions: the blocking of personal goals, the absence of positive stimuli, and the presence of negative stimuli. The first type of strain involves the obstruction of personal goals. The second type of strain refers to the loss of a loved one, such as a partner or significant other. The third type of strain encompasses traumatic events like inhumane treatment, neglect, and abusive behavior [25].

4.1. Socioeconomic and Demographic Factors

Understanding the social dynamics surrounding suicide is crucial, as it highlights the importance of addressing and reducing suicide risks to implement more effective early interventions [26]. Evidence strongly supports that poor economic status and deprivation are significant risk factors for suicide [27–29]. A recent systematic review of contributing factors revealed that two major reasons behind suicide are unemployment and low socioeconomic status [30]. The study argued that suicide decisions are not always illogical, as according to the classic economic theory of suicide, suicide is rationalized after analyzing the costs and benefits. The rise and fall of suicide rates vary with unemployment, the level of economic development, and educational achievement. When adolescents and young people face adversity and challenges at a young age, it becomes a significant risk factor for suicide. Similarly to our study, a recent study also highlights that high suicide risk was associated with low educational attainment and ethnic disparities [31].

Our findings are perfectly corroborated by a recent qualitative study from neighboring India that showed that "interpersonal stressors, particularly in young age females", shortly before a suicide attempt produce distorted cognitions and irresistible emotions of anxiety or anger due to relationship issues with partners or family members deeply rooted in sociocultural norms. This study recommends fostering life skills for young people and high-risk groups, such as women, curbing access to harmful substances, and involving family stakeholders [31,32].

Factors within the household, such as strained relationships and emotional neglect, contribute to feelings of hopelessness and despair [33–35]. When desperation, dissatisfaction, and abuse intersect, they significantly increase the risk of suicidal behavior [36–39]. In Pakistan, mental health awareness remains limited, leading many to attribute psychological distress to supernatural reasons such as divine punishment, curses, or magic [40]. the literature has revealed that individuals who engage in self-harm or attempt suicide often experience higher levels of depression [41,42]. Consequently, vulnerable members resort to sacrificing their own lives or those of their children, or offer symbolic items like roosters, goats, or prayers in the expectation of alleviating their suffering.

4.2. Gendered Vulnerability and Violence

The findings reveal that women often face harsh criticism from their family and relatives, which leads to feelings of isolation and hopelessness. Research suggests that gender-based vulnerabilities may contribute to an increased risk of suicidal behavior.

Insults in front of family members and the mistreatment of women are significantly linked to suicidal behavior. Rural women, in particular, are disproportionately affected by violence, discrimination, and emotional distress, which have been linked to suicidal actions [43]. The literature showed that corporal punishment, spiritual abuse, collaborative brutality, living in oppression, and being imprisoned in a household caused suicide [44]. Evidence indicated that family violence and social humiliation produced emotions in which no other choice is recognized except suicide in India [45] and Nepal [46].

Research indicates that violence poses significant risks to women's mental health. In tribal Pashtun culture, parents often arrange marriages for their daughters and sisters without considering their preferences. This lack of agency can lead to household conflicts and disputes with husbands, which, in turn, may result in women attempting self-harm [47,48]. A study found that ongoing and severe mistreatment from partners has detrimental effects on women's psychological well-being [49,50]. Some cases also reported injuries resulting from violence against women [24]. Increasing evidence of physical, sexual, and emotional abuse indicates a decline in women's mental health [51,52]. Similar research suggests that violence is more prevalent in LMICs where resources are distributed unequally [53].

4.3. Marital and Family Dynamics

Women identified marital conflicts as a major reason for suicide [54]. A study indicated that marital conflict, abusive arguments, and physical violence against women contribute to suicide [41]. Suicides among women in the Malakand division were prompted by marital issues, violence, and other factors [55]. Evidence shows that suicidal behavior among adolescents and young adults, caused by an unfriendly family atmosphere, broken interactions between family members, and an absence of perceived family support, might lead to suicide. Therefore, these causes must be anticipated before suicide prevention planning [56]. A study in Pakistan [57] found that adverse childhood experiences led to significant stress, anxiety, and insecurity among children. A study found that if a woman experiences stigmatization, violence, labeling, and abuse from her family, there is a critical need for social support programs such as shelters, group homes, and social networks to assist [35]. In Uganda, women often resort to suicide in response to household problems and a lack of social support [58].

Additionally, forced marriage is considered a violation of women's and girls' rights. Partners are often pressured and coerced into marriage through domestic violence [59]. This coercion undermines their freedom and dignity, effectively forcing them into the role of a spouse. Studies have shown that suicidal behavior among adolescents and young adults is influenced by perceived domestic factors, including aggressive home environments, critical comments, a lack of validation from mothers, and insufficient emotional support from family members [56]. Parental conflicts disrupt the home environment. Parents who are unwilling to engage in positive conversations, parental separation, and abuse contribute to suicidal behavior [56]. Research has identified that issues like a lack of respect and empathy, along with spiritual neglect from the family, are primary reasons for self-harm [60]. Another study conducted in Nepal [54] found that poor marital conditions, abuse, and neglect by husbands often contribute to suicide among women.

Our results indicated that some women died by suicide because of unfulfilled sexual needs as they were forced to marry aged men. A study conducted in Sweden highlights that in heterosexual relationships, men and women are on an equal footing when it comes to the key aspect of "sexual pleasure on equal terms". They achieve mutual sexual desire and satisfy each other's needs [61]. In Pakistan, it is rare for individuals to choose their spouses [62]. Pridmore [63] notes that major causes of suicide include issues related to fate, well-being, freedom, and honor. Researchers have observed similar issues in the district of

Chitral, Khyber Pakhtunkhwa, Pakistan, where conflicts, unmet desires, and a lack of hope are prevalent [64].

4.4. Family Honor and Ethnic and Cultural Violence

This study reveals that the respect and dignity (izzat) associated with family or caste are significant causes of suicide in rural and tribal areas. People are extremely concerned about the honor of their family (Baradari). Daughters have little opportunity for love marriages, and if a girl falls in love, her parents may respond with anger, violence, and aggression. If a girl marries and runs away with a boy, her parents often refuse to accept her back, closing their doors to her rebellious actions. Without support from their parents and with limited interaction with family, many women view death as the only solution to their problems. In Nepal, the shame and social exclusion experienced by girls who marry and leave school at a young age are largely responsible for their disallowed attachment connections [54].

Feelings of anger, depression, irritation, and dissatisfaction become sources of strain, potentially leading to crime or suicide [65]. In South India, cultural values, normative behaviors, and family structures prevent clinicians and therapists from referring suicide attempt survivors for further help [66]. Evidence from other South Asian countries, such as Nepal [67], also suggests that a family's izzat (social status) is a major concern. Hagaman [68], a medical anthropologist, suggested adding familial perspectives and experiences to high-level policy and planning.

4.5. Methods and Means of Suicide

Research indicates that victims utilized various methods for suicide, including black rock (often mixed with juice), insecticides, pesticides, hanging, and nail polish remover. While all these methods pose significant risks, black rock was identified as the most lethal, leaving no chance of survival. Many women used "black rock", a substance commonly found in grocery stores that is typically used for dyeing hair. According to previous studies, women have been known to use benzodiazepines or organophosphate pesticides as methods of suicide [69]. Given the severe dangers associated with pesticides, some studies [70,71] suggest that rural and agricultural communities should take measures to restrict young women's access to these substances.

4.6. Limitations and Strengths of the Study

Our study has some limitations. First, it is specific to the context of the Southern Punjab province of Pakistan, which may limit its generalizability to other ethnic or cultural settings of the country. Secondly, the sample size is not very large, which could further restrict the broader applicability of the findings. Thirdly, interviewing relatives may also introduce potential exaggeration or personal bias in our qualitative data. Despite these limitations, there are key strengths of this study. It is a novel contribution to exploring young and rural women and sociocultural and marital factors, a topic that has rarely been examined before. Furthermore, the use of in-depth interviews and rapport-building in an ethnographic approach adds depth and credibility to this research.

5. Conclusions

In this study, we investigated the primary motives behind women's suicides in the South Punjab region of Pakistan. Our findings revealed that the prominent factors revolved around marital life, including relationship failures, desperation, violence, family torture, abuse, impatience, poverty, forced marriages, and fear of their husbands. Forced [or exchange] marriages must be closely monitored, and those involved should be held legally accountable. Empowering women and ensuring their economic independence can

eliminate their dependency on in-laws and relatives, thereby preventing the insult and abuse often faced by dependent women. Providing emotional health counseling for young women can offer crucial support and improve their quality of life. Additionally, there is a pressing need for improved emergency care, and the government should take steps to ban the sale of harmful and deadly products. This highlights the importance of Integrating suicide prevention initiatives with research efforts within Pakistan's healthcare system.

Author Contributions: Conceptualization and data collection: F.A. and S.Z.; methodology: F.A., R.A., N.I.M., R.N. and J.S.W.; data analysis: F.A., E.Y.H.T., R.N., J.S.W. and R.A.; supervision: F.A.; writing—original draft: F.A. and S.Z.; writing—review and editing: R.A., E.Y.H.T., N.I.M., R.N., J.S.W. and Y.F. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Department of Anthropology at the Islamia University of Bahawalpur granted ethical approval for this study (IUB/ANTH/99; date of approval 5 June 2024).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study. The participants' thoughts, experiences, and perceptions were treated with the utmost confidentiality.

Data Availability Statement: The original contributions presented in this study are included in the article. Further inquiries can be directed to the corresponding author(s).

Acknowledgments: We would like to acknowledge the respondents for sharing their views.

Conflicts of Interest: The authors declare no conflicts of interest.

References

1. World Health Organization. Suicide. World Health Organization. 2019. Available online: https://www.who.int/news-room/fact-sheets/detail/suicide (accessed on 15 May 2012).
2. Shakil, M. A Qualitative Analysis of Suicides Committed by the Students in Pakistan. *Pak. J. Med. Res.* **2019**, *58*, 35–40.
3. World Health Organization. *Preventing Suicide: A Global Imperative*; World Health Organization: Geneva, Switzerland, 2014.
4. Turecki, G.; Brent, D. Suicide and Suicidal Behaviour. *Lancet* **2016**, *387*, 1227–1239. [CrossRef]
5. World Health Organization. *Global Health Observatory*; World Health Organization: Geneva, Switzerland, 2017.
6. Shah, I.; Khalily, M.T.; Ahmad, I.; Hallahan, B. Impact of Conventional Beliefs and Social Stigma on Attitude Towards Access to Mental Health Services in Pakistan. *Community Ment. Health J.* **2019**, *55*, 527–533. [CrossRef]
7. Tabassum, R. Gender Inequality in Mental Health: A Review from the South Asian Context. *Bangladesh J. Med. Sci.* **2017**, *16*, 203–206. [CrossRef]
8. Kiran, T.; Chaudhry, N.; Bee, P.; Tofique, S.; Farooque, S.; Qureshi, A.; Taylor, A.K.; Husain, N.; Chew-Graham, C.A. Clinicians' Perspectives on Self-Harm in Pakistan: A Qualitative Study. *Front. Psychiatry* **2021**, *12*, 607549. [CrossRef]
9. Mahmood, S. *The Pakistan Penal Code (XLV of 1880)*; Legal Research Centre: Lahore, Pakistan, 1989; Volume II.
10. De Leo, D. Can We Rely on Suicide Mortality Data? *Crisis* **2015**, *36*, 1–3. [CrossRef]
11. Dwivedi, Y. (Ed.) *The Neurobiological Basis of Suicide*; CRC Press: Boca Raton, FL, USA, 2012.
12. Marecek, J.; Senadheera, C. 'I Drank It to Put an End to Me': Narrating Girls' Suicide and Self-Harm in Sri Lanka. *Contrib. Indian Sociol.* **2012**, *46*, 53–82. [CrossRef]
13. Lester, D. *Why Women Kill Themselves*; Charles C. Thomas: Springfield, IL, USA, 1988.
14. Tomlinson, M. *Dealing with Suicide*; KESS Seminar Series; Stormont Assembly: Belfast, UK, 2013.
15. Rugkhla, P. *Women and Suicide*; Gender Impact Assessment; Women's Health Victoria: Melbourne, Australia, 2011.
16. Mallon, S.; Galway, K.; Hughes, L.; Rondón-Sulbarán, J.; Leavey, G. An Exploration of Integrated Data on the Social Dynamics of Suicide Among Women. *Sociol. Health Illn.* **2016**, *38*, 662–675. [CrossRef]
17. Ahmed, F.; Malik, N.I.; Bashir, S.; Noureen, N.; Ahmad, J.B.; Tang, K. Political Economy of Maternal Child Malnutrition: Experiences about Water, Food, and Nutrition Policies in Pakistan. *Nutrients* **2024**, *16*, 2642. [CrossRef]
18. Ahmed, F.; Malik, N.I.; Bashir, S.; Noureen, N.; Ullah, S.; Ahmed, J.B.; Mansoor, T. "An obedient wife never says 'no' to her virtual god". High fertility conceptions and barriers to contraceptive use among mothers of Southern Pakistan: A qualitative study. *BMC Public Health* **2024**, *24*, 2157. [CrossRef]

19. Shahid, M.; Ahmed, F.; Ameer, W.; Guo, J.; Raza, S.; Fatima, S.; Qureshi, M.G. Prevalence of child malnutrition and household socioeconomic deprivation: A case study of marginalized district in Punjab, Pakistan. *PLoS ONE* **2022**, *17*, e0263470. [CrossRef]
20. Ahmed, F.; Shahid, M.; Cao, Y.; Qureshi, M.G.; Zia, S.; Fatima, S.; Guo, J. A qualitative exploration in causes of water insecurity experiences, and gender and nutritional consequences in South Punjab, Pakistan. *Int. J. Environ. Res. Public Health* **2021**, *18*, 12534. [CrossRef]
21. Ahmed, F.; Malik, N.I.; Shahzad, M.; Ahmad, M.; Shahid, M.; Feng, X.L.; Guo, J. Determinants of Infant Young Child Feeding Among Mothers of Malnourished Children in South Punjab, Pakistan: A Qualitative Study. *Front. Public Health* **2022**, *10*, 834089. [CrossRef]
22. Ahmed, F.; Malik, N.I.; Zia, S.; Akbar, A.S.; Li, X.; Shahid, M.; Tang, K. Rural mothers' beliefs and practices about diagnosis, treatment, and management of children health problems: A qualitative study in marginalized Southern Pakistan. *Front. Public Health* **2023**, *10*, 1001668. [CrossRef]
23. Ahmed, F.; Malik, N.I.; Malik, N.; Qureshi, M.G.; Shahzad, M.; Shahid, M.; Zia, S.; Tang, K. Key challenges to optimal therapeutic coverage and maternal utilization of CMAM Program in rural southern Pakistan: A qualitative exploratory study. *Nutrients* **2022**, *14*, 2612. [CrossRef]
24. Braun, V.; Clarke, V. One Size Fits All? What Counts as Quality Practice in (Reflexive) Thematic Analysis? *Qual. Res. Psychol.* **2020**, *18*, 328–352. [CrossRef]
25. Agnew, R. General Strain Theory: Current Status and Directions for Further Research. In *Taking Stock: The Status of Criminological Theory*; Cullen, F.T., Wright, J.P., Blevins, K.R., Eds.; Transaction Publishers: New Brunswick, NJ, USA, 2006; pp. 101–123.
26. Björkenstam, C.; Kosidou, K.; Björkenstam, E. Childhood Adversity and Risk of Suicide: Cohort Study of 548,721 Adolescents and Young Adults in Sweden. *BMJ* **2017**, *357*, j1334. [CrossRef]
27. Skegg, K. Self-Harm. *Lancet* **2005**, *366*, 1471–1483. [CrossRef]
28. Shahid, M.; Khan, M.M.; Saleem Khan, M.; Jamal, Y.; Badshah, A.; Rehmani, R. Deliberate Self-Harm in the Emergency Department: Experience from Karachi, Pakistan. *Crisis* **2009**, *30*, 85–89. [CrossRef]
29. Shekhani, S.S.; Perveen, S.; Hashmi, D.-E.; Akbar, K.; Bachani, S.; Khan, M.M. Suicide and Deliberate Self-Harm in Pakistan: A Scoping Review. *BMC Psychiatry* **2018**, *18*, 44. [CrossRef]
30. Stack, S. Contributing Factors to Suicide: Political, Social, Cultural and Economic. *Prev. Med.* **2021**, *152*, 106498. [CrossRef]
31. Messias, E.; Azasu, E.K.; Nayeem, N.; Lin, P.-I.; Grucza, R. Suicide Deaths by Occupation Skill Level and Educational Attainment in the United States. *J. Occup. Health* **2025**, *67*, uiae078. [CrossRef] [PubMed]
32. Balaji, M.; Mandhare, K.; Nikhare, K.; Shah, A.K.; Kanhere, P.; Panse, S.; Santre, M.; Vijayakumar, L.; Phillips, M.R.; Pathare, S.; et al. Why Young People Attempt Suicide in India: A Qualitative Study of Vulnerability to Action. *SSM-Ment. Health* **2023**, *3*, 100216. [CrossRef]
33. Bilsen, J. Suicide and Youth: Risk Factors. *Front. Psychiatry* **2018**, *9*, 540. [CrossRef]
34. Bagge, C.L.; Lamis, D.A.; Nadorff, M.R.; Osman, A. Relations Between Hopelessness, Depressive Symptoms and Suicidality: Mediation by Reasons for Living. *J. Clin. Psychol.* **2014**, *70*, 18–31. [CrossRef]
35. Ali, T.S.; Krantz, G.; Gul, R.; Asad, N.; Johansson, E.; Mogren, I. Gender Roles and Their Influence on Life Prospects for Women in Urban Karachi, Pakistan: A Qualitative Study. *Glob. Health Action* **2011**, *4*, 7448. [CrossRef]
36. Van Orden, K.A.; Witte, T.K.; Cukrowicz, K.C.; Braithwaite, S.; Selby, E.A.; Joiner, T.E. The Interpersonal Theory of Suicide. *Psychol. Rev.* **2010**, *117*, 575–600. [CrossRef] [PubMed]
37. Kuo, W.H.; Gallo, J.J.; Eaton, W.W. Hopelessness, Depression, Substance Disorder, and Suicidality: A 13-Year Community-Based Study. *Soc. Psychiatry Psychiatr. Epidemiol.* **2004**, *39*, 497–501. [CrossRef] [PubMed]
38. Smith, J.M.; Alloy, L.B.; Abramson, L.Y. Cognitive Vulnerability to Depression, Rumination, Hopelessness, and Suicidal Ideation: Multiple Pathways to Self-Injurious Thinking. *Suicide Life-Threat. Behav.* **2006**, *36*, 443–454. [CrossRef]
39. Spirito, A.; Esposito-Smythers, C. Attempted and Completed Suicide in Adolescence. *Annu. Rev. Clin. Psychol.* **2006**, *2*, 237–266. [CrossRef]
40. Gilani, A.I.; Gilani, U.I.; Kasi, P.M.; Khan, M.M. Psychiatric Health Laws in Pakistan: From Lunacy to Mental Health. *PLoS Med.* **2005**, *2*, e317. [CrossRef] [PubMed]
41. Rezaie, L.; Hosseini, S.A.; Rassafiani, M.; Najafi, F.; Shakeri, J.; Khankeh, H. Why Self-Immolation? A Qualitative Exploration of the Motives for Attempting Suicide by Self-Immolation. *Burns* **2014**, *40*, 319–327. [CrossRef]
42. Roohafza, H.; Mosharraf, S.; Mousavi, G.; Khani, A.; Andalib, E.; Reihani, M. The Prevalence and Determinants of Suicidal Behaviors in the Central Region of Iran. *Int. J. Body Mind Cult.* **2014**, *1*, 142–153.
43. Pillai, A.; Andrews, T.; Patel, V. Violence, Psychological Distress and the Risk of Suicidal Behavior in Young People in India. *Int. J. Epidemiol.* **2009**, *38*, 459–469. [CrossRef]

44. LeMasters, K.; Bates, L.M.; Chung, E.O.; Gallis, J.A.; Hagaman, A.; Scherer, E.; Sikander, S.; Staley, B.S.; Zalla, L.C.; Zivich, P.N.; et al. Adverse Childhood Experiences and Depression among Women in Rural Pakistan. *BMC Public Health* **2021**, *21*, 400. [CrossRef]
45. Vijaykumar, L. Suicide and Its Prevention: The Urgent Need in India. *Indian J. Psychiatry* **2007**, *49*, 81–84. [CrossRef]
46. Pradhan, A.; Poudel, P.; Thomas, D.; Barnett, S. *A Review of the Evidence: Suicide among Women in Nepal*; National Health Sector Support Program, Ministry of Health and Population: Kathmandu, Nepal, 2011; Volume 117.
47. Sajid, I. Suicides Rising Among Women in Northern Pakistan. *Anadolu Agency*. 2018. Available online: https://www.aa.com.tr/en/asia-pacific/suicides-rising-among-women-in-northern-pakistan/1270469 (accessed on 18 April 2021).
48. Ali, T.S.; Mogren, I.; Krantz, G. Intimate Partner Violence and Mental Health Effects: A Population-Based Study Among Married Women in Karachi, Pakistan. *Int. J. Behav. Med.* **2013**, *20*, 131–139. [CrossRef]
49. Campbell, J.C.; Kub, J.; Belknap, R.A.; Templin, T.N. Predictors of Depression in Battered Women. *Violence Against Women* **1997**, *3*, 271–293. [CrossRef]
50. Farooq, U.; Majeed, M.; Bhatti, J.A.; Khan, J.S.; Razzak, J.A.; Khan, M.M. Differences in Reporting of Violence and Deliberate Self-Harm-Related Injuries to Health and Police Authorities, Rawalpindi, Pakistan. *PLoS ONE* **2010**, *5*, e9373. [CrossRef]
51. Pico-Alfonso, M.A.; Garcia-Linares, M.I.; Celda-Navarro, N.; Blasco-Ros, C.; Echeburúa, E.; Martinez, M. The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety, and Suicide. *J. Womens Health* **2006**, *15*, 599–611. [CrossRef]
52. Khan, M.M. Suicide Prevention and Developing Countries. *J. R. Soc. Med.* **2005**, *98*, 459–463. [CrossRef] [PubMed]
53. Houry, D.; Kemball, R.; Rhodes, K.V.; Kaslow, N.J. Intimate Partner Violence and Mental Health Symptoms in African American Female ED Patients. *Am. J. Emerg. Med.* **2006**, *24*, 444–450. [CrossRef]
54. Hagaman, A.K.; Khadka, S.; Wutich, A.; Lohani, S.; Kohrt, B.A. Suicide in Nepal: Qualitative Findings from a Modified Case-Series Psychological Autopsy Investigation of Suicide Deaths. *Cult. Med. Psychiatry* **2018**, *42*, 704–734. [CrossRef] [PubMed]
55. Geo News. 346 People Committed Suicide in Malakand in Last Eight Months. *Geo News*. 2018. Available online: https://www.geo.tv/latest/212922 (accessed on 18 April 2021).
56. Mathew, A.; Saradamma, R.; Krishnapillai, V.; Muthubeevi, S.B. Exploring the Family Factors Associated with Suicide Attempts among Adolescents and Young Adults: A Qualitative Study. *Indian J. Psychol. Med.* **2021**, *43*, 113–118. [CrossRef]
57. Ikram, N.; Frost, A.; LeMasters, K.; Hagaman, A.; Baranov, V.; Gallis, J.; Sikander, S.; Scherer, E.; Maselko, J. Adverse Childhood Experiences and Implications of Perceived Stress, Anxiety, and Cortisol Among Women in Pakistan. *BMJ Open* **2021**, *12*, e052280. [CrossRef] [PubMed]
58. Kizza, D.; Knizek, B.L.; Kinyanda, E.; Hjelmeland, H. An Escape from Agony: A Qualitative Psychological Autopsy Study of Women's Suicide in a Post-Conflict Northern Uganda. *Int. J. Qual. Stud. Health Well-being* **2012**, *7*, 18463. [CrossRef]
59. Pascali, M. La Riforma Normativa Sulla Violenza Sulle Donne in Relazione Alla Natura Dei Crimini Perpetrati. *Riv. Criminol. Vittimol. Sicurezza* **2015**, *9*, 1–45. [CrossRef]
60. Ghalambor, A.; Zarei, J.; Pipelzadeh, M.H. Assessment of Personal and Social Characteristics as Risk Factors in Self-Inflicted Burns. *Med. Sci. J.* **2010**, *9*, 233–246.
61. Elmerstig, E.; Wijma, B.; Sandell, K.; Berterö, C. "Sexual Pleasure on Equal Terms": Young Women's Ideal Sexual Situations. *J. Psychosom. Obstet. Gynecol.* **2012**, *33*, 129–134. [CrossRef]
62. Law, L.W.S. *Child, Early and Forced Marriage: A Multi-Country Study*; UN Office of the High Commissioner for Human Rights: Geneva, Switzerland, 2013.
63. Pridmore, S.; Walter, G. Suicide and Forced Marriage. *Malays. J. Med. Sci.* **2013**, *20*, 47–50.
64. Ahmed, Z.; Nisa, Q.; Yousufzai, A.W.; Khoja, S.; Chaudhry, J. Trends and Patterns of Suicide in People of Chitral, Khyber Pakhtunkhwa, Pakistan. *Khyber Med. Univ. J.* **2016**, *8*, 72–77.
65. Zhang, J.; Wieczorek, W.F.; Conwell, Y.; Tu, X.M. Psychological Strains and Youth Suicide in Rural China. *Soc. Sci. Med.* **2011**, *72*, 2003–2010. [CrossRef] [PubMed]
66. Lasrado, R.A.; Chantler, K.; Jasani, R.; Young, A. Structuring Roles and Gender Identities Within Families Explaining Suicidal Behavior in South India. *Crisis* **2016**, *37*, 205–213. [CrossRef]
67. Hagaman, A.K.; Maharjan, U.; Kohrt, B.A. Suicide Surveillance and Health Systems in Nepal: A Qualitative and Social Network Analysis. *Int. J. Ment. Health Syst.* **2016**, *10*, 58. [CrossRef] [PubMed]
68. Hagaman, A.K. Hidden Death and Social Suffering: A Critical Investigation of Suicide, Death Surveillance, and Implications for Addressing a Complex Health Burden in Nepal. Ph.D. Thesis, Arizona State University, Tempe, AZ, USA, 2017. Available online: https://keep.lib.asu.edu/items/155678 (accessed on 25 October 2023).
69. Khan, M.M.; Mahmud, S.; Karim, M.S.; Zaman, M.; Prince, M. Case-Control Study of Suicide in Karachi, Pakistan. *Br. J. Psychiatry* **2008**, *193*, 402–405. [CrossRef]

70. Karunarathne, A.; Gunnell, D.; Konradsen, F.; Eddleston, M. How Many Premature Deaths from Pesticide Suicide Have Occurred Since the Agricultural Green Revolution? *Clin. Toxicol.* **2020**, *58*, 227–232. [CrossRef]
71. Lee, Y.Y.; Chisholm, D.; Eddleston, M.; Gunnell, D.; Fleischmann, A.; Konradsen, F.; Bertram, M.Y.; Mihalopoulos, C.; Brown, R.; Santomauro, D.F.; et al. The Cost-Effectiveness of Banning Highly Hazardous Pesticides to Prevent Suicides Due to Pesticide Self-Ingestion across 14 Countries: An Economic Modeling Study. *Lancet Glob. Health* **2021**, *9*, e291–e300. [CrossRef]

healthcare

MDPI

Article

Rates of Suicide Ideation and Associated Risk Factors Among Female Secondary School Students in Iraq

Saad Sabet Alatrany [1,2,†], Molly McCarthy [3], Ashraf Muwafaq Flaiyah [1,2], Emma Ashworth [3], Hasan ALi Sayyid ALdrraji [2,4], Abbas Saad Alatrany [5,6], Dhiya Al-Jumeily [7], Sarmad Nadeem [8], Jo Robinson [9] and Pooja Saini [3,*,†]

1 Department of Clinical Psychology, Imam Ja'afar Al-Sadiq University, Baghdad 10001, Iraq; saad.alatrany@ijsu.edu.iq (S.S.A.); ashraf.flaiyah@ijsu.edu.iq (A.M.F.)
2 Ibn Reshed College of Education for Human Sciences, University of Baghdad, Baghdad 10071, Iraq; hassan.sayid@ircoedu.uobaghdad.edu.iq
3 School of Psychology, Liverpool John Moores University, Liverpool L3 3AF, UK; m.mccarthy1@ljmu.ac.uk (M.M.); e.l.ashworth@ljmu.ac.uk (E.A.)
4 Baghdad Centre for Psychosocial Support, Baghdad 10091, Iraq
5 Biomedical Informatics College, University of Information Technology and Communications, Baghdad 10066, Iraq; assa9@leicester.ac.uk
6 Department of Cardiovascular Sciences, University of Leicester and the NIHR Leicester Biomedical Research Centre, Glenfield Hospital, Leicester LE3 9QP, UK
7 School of Computer Science and Mathematics, Liverpool John Moores University, Liverpool L3 3AF, UK; d.aljumeily@ljmu.ac.uk
8 Pennine Care NHS Foundation Trust, Lancashire OL6 7SR, UK; sarmad.nadeem@nhs.net
9 Centre for Youth Mental Health, The University of Melbourne, Parkville, VIC 3010, Australia; jo.robinson@orygen.org.au
* Correspondence: p.saini@ljmu.ac.uk; Tel.: +44-0151-231-8121
† These authors contributed equally to this work.

Abstract: Background: The suicide rate among Iraqis is rising, with many analysts attributing it to political instability, exposure to trauma, economic hopelessness, social stigma surrounding mental health as well as cultural and societal pressures. However, the prevalence of suicidal ideation and associated risk factors in Iraqi youth is unknown, requiring urgent attention and effective public health initiatives. Thus, the aim of this study was to explore rates of suicidal ideation and associated risk factors among female secondary school students in Baghdad, Iraq. Method: A cross-sectional study was conducted, utilising quantitative survey data collected in four girls' secondary schools across Baghdad, Iraq, between August and December 2023. The survey consisted of questions relating to their demographic characteristics (age, gender, school) and a series of measures pertaining to participants' levels of suicidal ideation, as well as factors commonly identified in the literature as predictors of suicide. Results: Four-hundred and two female participants took part. Participants were aged between 13 and 17 years (M = 15.50; SD = 1.22). In total 11.3% of the students scored in the at-risk range for suicidal behaviour and only 20.1% (n = 91) said they had not had some thoughts of suicide in the previous two weeks. Previous diagnoses of anxiety, high levels of depression and hopelessness, and poor quality of life were significant risk factors for suicidal ideation. On average, students reported moderate levels of depression and high levels of hopelessness. Conclusions: Female Iraqi secondary school students experience high levels of suicidality, alongside several other known risk factors for suicide ideation. However, a limitation of this study is that cross-sectional designs limit causal interpretation. Findings emphasise the importance of developing targeted school-based interventions to support students' mental health. Increasing research and attention in this area is vital to not only improving the mental health of students in Iraq but also reducing the stigma around mental health and suicide. Future policies should include specific mental

health support for those young people affected by conflict, displacement and family loss, integrating trauma-informed care into both mental health and educational services.

Keywords: school; female; suicide; self-harm; suicide prevention

1. Background

Suicide is the second leading cause of death amongst youth aged 10 to 34 worldwide. Approximately 703,000 people die by suicide annually, and 20 suicide attempts occur for every suicide [1]. Therefore, practical strategies to prevent or reduce suicide are necessary. Data from the Iraq National Study of Suicide revealed that the crude suicide rate was 10.9/100,000 in 2016 [2] compared to 7.3/100,000 in 2017 in the UK [3], with statistics suggesting that deaths by suicide have been increasing each year since [4]. Among those who died, 36.6% were below the age of 20 [5]. There are particular concerns of a rising suicide rate among Iraqi youths, with many analysts suggesting it may be due to the economic hopelessness so many have experienced during childhood. However, little is known about the current suicide rate in Iraqi youth, or the key risk factors. The prevalence of suicidal ideation and associated risk factors in Iraq, therefore, requires urgent attention and effective public health initiatives, particularly targeting youth, who seem to have been omitted to date.

Basra recorded the highest rates of suicide or suicide attempts across Iraq, with the ages of those dying by suicide ranging from 18 to 30 years old [6]. However, the rates are generally considered to be an underestimate, as many people keep deaths by suicide hidden for social reasons. For instance, doctors in Iraq have reported facing pressure from relatives and tribal authorities to prevent post mortem examinations from investigating the cause of death for two key reasons: (1) due to socio-religious beliefs that the autopsy would damage the body, and (2) to cover up the real reason behind the death, as the family refuse to disclose it due to social stigma and religious concerns [7].

In Iraq, several other factors are thought to contribute to levels of suicide ideation, including intimate partner problems, physical health conditions, financial challenges, and legal issues [7]. Others are personal or family experiences of violence, including child abuse, neglect, and domestic violence, as well as family history of suicide and broader community conditions, such as high crime rates and violence [8]. The COVID-19 pandemic is also known to have contributed to an increase in several risk factors, such as rates of domestic violence in the country, with one survey reporting that currently one in five Iraqi women experience domestic violence [9].

Furthermore, the political situation in Iraq over the last two decades may present with several unique risk factors for adolescents and young adults, with particular reference to the Iraq mental health crisis [10]. For instance, many Iraqi children and their families have suffered with mental health scars caused by past conflicts, wars, and economic hostilities, including control by the Islamic State (ISIS) [11]. As a result, a study conducted in Mosul across eight secondary schools reported 30% had symptoms of post-traumatic stress disorder (PTSD), with rates higher in older adolescents [12]. Amplifying the existing mental health concerns among Iraqi youth is the lack of mental health support and treatment across the country [13]. These have been further compounded by the stay-at-home restrictions and limited movements required to curb the spread of COVID-19. Concerns of increased suicide ideation and associated risk factors have been highlighted by public health networks globally [9].

Iraqi females are thought to be disproportionately affected by suicidal ideation, self-harm and suicide attempts, often noted to be driven by factors such as familial conflict, economic dependence, and the limitations placed on women's roles within society [14]. For example, in a recent systematic review [7] young females represented higher levels of suicide attempts and ideation using potentially lethal methods such as self-burning, thought to be due to high rates of depression, as well as community and domestic violence. Furthermore, a comprehensive survey conducted in Iraq by the WHO in collaboration with the Iraqi Ministry of Health [15], the Iraqi Mental Health Survey (IMHS) 2006–2007, revealed that 5.4% of females had seriously considered suicide compared to 2.5% of males. Females were also nearly three times more likely to engage in suicide attempts. These findings are consistent with broader global trends where females, particularly adolescents and young women, are more vulnerable to non-lethal self-harm and suicide attempts, often to cope with psychological pain, depression, and trauma [4]. As such, work centred around female adolescents is imperative to ensure appropriate targeted support is on offer.

The current study aimed to explore rates of suicidal ideation and associated risk factors among female secondary school students in Baghdad, Iraq, a previously overlooked public health concern.

2. Methods

2.1. Design

The current cross-sectional study utilised quantitative survey data collected in secondary schools across Baghdad, Iraq, between August and December 2023.

2.2. Participants and Recruitment

Four female secondary schools were recruited to participate. Baghdad is divided into two parts, known as Karkh and Rusafa, by the Tigris River. Consequently, two female schools were selected from each part to ensure representation of schools across the city. Data collectors visited the four selected schools and, in coordination with the school principals, selected a maximum of two classrooms per school (with an average of 50 students per classroom). Students were invited to complete paper-based surveys in school, which included all measures stated below. If the parents/carers consented to their child taking part, students were invited to complete paper-based surveys in school. To maintain participant privacy, female data collectors were assigned to female schools. Informed assent was sought from the students, who were asked to tick a box at the beginning of the questionnaire if they consented to taking part. Students were informed that participation was voluntary, and they could leave before or during the completion of the questionnaires without any negative consequences. Some students chose to leave before starting or did not complete the questionnaires (n = 27; 6%). The study received ethical approval on 15 August 2023 Imam Ja'afar Al-Sadiq University, College of Arts Ethical Approval Committee (Ref: 2023-01).

2.3. Measures

The survey consisted of two parts: Part 1 asked participants questions relating to their demographic characteristics (age, gender, school), while Part 2 presented a series of measures pertaining to participants' levels of suicidal ideation, as well as factors commonly identified in the literature as predictors of suicide (outlined below). All measurements have been validated for use with adolescent populations except for the brief two-item hopelessness measure.

2.3.1. Suicidal Ideation

Suicidal ideation was assessed via the Suicidal Ideation Attributes Scale (SIDAS) [16]. The SIDAS is a self-report measure designed to screen individuals in the community for the presence of suicidal thoughts and assess the severity of these thoughts, over the past month. It comprises five items, each targeting an attribute of suicidal thoughts: frequency, controllability, closeness to attempt, level of distress associated with the thoughts, and impact on daily functioning. Responses are measured on a 10-point scale. Total SIDAS scores are calculated as the sum of the five items, with controllability reverse scored, and with total scale scores ranging from 0 to 50. A higher total score reflects more severe suicidal thoughts. Scores over 21 represent the clinically significant threshold for high-risk suicide ideation.

2.3.2. Depression and Suicidal Thoughts and Plans

Depression symptoms were assessed using the Patient Health Questionnaire-9-item version (PHQ-9) [17]. Participants are asked to indicate how often they have been bothered by nine problems over the past two weeks. Each item is rated on a four-point Likert scale ranging from 0 ("not at all") to 3 ("nearly every day"). Scores are summed such that the potential range is 0–27, with higher scores indicative of greater distress. Clinical thresholds are provided, indicating 'mild', 'moderate', 'moderately severe' and 'severe' depressive symptoms. The final question of the PHQ-9 asks participants to indicate the number of days they have had thoughts that they would be better off dead or hurting themselves in some way. If they indicated any suicidal thoughts, participants were presented with a purpose-designed item, asking them to indicate which of the following describes the level of suicidal ideation they were experiencing: "Mild suicidal thoughts with no plan or intent to act"; "Moderate suicidal thoughts with a rough plan and some intent"; "Severe suicidal thoughts with a specific plan and intent to act".

2.3.3. Hopelessness

Hopelessness was assessed using the Brief-H-Pos, a two-item positively worded measure of hopelessness [18]. Respondents indicate agreement on a five-point scale (range 2–10), with lower scores indicating higher hopelessness.

2.3.4. Help-Seeking Intentions

Intentions to seek help were assessed using part two of the General Help Seeking Questionnaire (GHSQ) [19]. The GHSQ presents participants with a list of potential sources of help and asks them to indicate the likelihood that they would approach that source if they were experiencing suicidal thoughts on a five-point scale (very unlikely-very likely). Higher scores indicate greater levels of intended help-seeking.

2.3.5. Health-Related Quality of Life

Health-related quality of life was assessed using the Child Health Utility–9 (CHU9D) [20]. The CHU9D is a multi-attribute utility instrument suitable for young people aged 7–17 years. The questionnaire has nine items, each with a five-level response category that assesses a young person's functioning "today" across various domains. The total score ranges from 0 to 40, with higher values indicating greater behavioural and emotional difficulties.

2.3.6. Suicide Literacy

Suicide literacy was assessed using an adapted version of the Literacy of Suicide Scale (LOSS) short form to ascertain participants knowledge about suicide [21]. This contains nine statements about suicide and asks participants to rate whether they believe it is true,

false, or they do not know. The scale provides a total literacy score (percent correct), where higher scores indicate greater suicide literacy.

2.4. Procedure and Analytic Strategy

A pre-testing pilot was conducted to test the translation of the survey from English to Arabic on a small group similar to the target population (n = 7). The survey was then distributed within schools. See Box 1 for more information on the translation process.

Prior to analysis, participants' responses on the paper-based surveys were scanned using Remark Office OMR software Version 11 by data entry personnel. The file was then imported into IBM SPSS Version 29 for analysis.

This was an exploratory analysis, whereby descriptive statistics were conducted to identify the socio-demographics of the sample and the factors characteristic of students experiencing suicide ideation. To achieve this, we conducted the following set of analyses. Descriptive analysis (e.g., means, standard deviations, frequencies, percentages) were used to characterise the overall sample in terms of age, gender, ethnicity, academic status, and other socio-demographic variables. Next, chi-squared analyses were used to assess associations between categorical variables (e.g., gender and suicidal thoughts), as well as independent sample *t*-tests and one-way ANOVAs to compare means of continuous variables (e.g., levels of stress, social support) across groups defined by the presence or absence of suicide ideation or across multiple categorical groups (e.g., academic year). Association analyses using Spearman's Rank correlation were also employed to examine relationships between continuous and ordinal variables (e.g., perceived stress and suicidal ideation scores). Regression analyses were then conducted with suicide ideation and suicidal thoughts as outcome variables to identify significant predictors. We did not conduct Bonferroni corrections for multiple comparisons based on recommendations from Armstrong [22] and Rothman [23] that corrections for multiple comparisons in exploratory studies are not required, due to the increased likelihood of Type 2 errors.

Box 1. Translation process.

1.	**Formation of Translation Teams:**
	• A translation team was established, comprising a professional English translator and a professor specialising in clinical psychology who is proficient in English.
2.	**Translation of Questionnaires:**
	• The team translated the questionnaires from English to Arabic.
3.	**Language Review:**
	• The translated questionnaires were reviewed by an Arabic language specialist to ensure linguistic accuracy and appropriateness for secondary school students.
4.	**Back-Translation:**
	• A second team was formed, consisting of a professional English translator and a professor specialising in clinical psychology who is proficient in English. This team performed a back-translation of the Arabic questionnaires into English.
5.	**Review and Finalisation:**
	• A meeting was held between the two translation teams to discuss feedback regarding the translations and to agree on a finalised Arabic version of the questionnaires.

3. Results

3.1. Demographic Characteristics

A total of 452 female participants took part. Participants were aged between 13 and 17 years (M = 15.50; SD = 1.22). The most common mental health diagnosis reported by students was anxiety (n = 190; 42%), followed by depression (n = 99; 21.9%) and obsessive-compulsive disorder (OCD; n = 77; 17.0%). The prevalence of neurodivergent conditions

was broadly in-line with international rates, with 2.0% (n = 9) reporting an autism diagnosis and 11.1% (n = 50) reporting a diagnosis of attention deficit hyperactivity disorder (ADHD). See Appendix A Table A1 which provides the breakdown of mental health diagnosis.

3.2. Suicidal Ideation (SIDAS)

Mean scores for suicide ideation on the SIDAS were 8.45 (SD = 10.30) out of a maximum score of 50 (range = 0–50). Seven participants (1.5%) had the maximum possible score. Responses to the individual items are presented on Appendix A Table A2.

A total of 11.3% of the students (n = 51) scored in the at-risk range for suicidal behaviour (a score $\geq$ 21). This was consistent across age groups. A logistic regression was performed to identify significant predictors of high-risk SIDAS scores. The overall model was statistically significant (c^2 (1) = 186.127, $p < 0.001$), explaining 17.5% of the variation (Nagelkerke R^2). Depression ($p = 0.001$), quality of life ($p = 0.003$), and hopelessness ($p = 0.044$) were significant predictors of high-risk SIDAS scores. Table 1 provides further details.

Table 1. A logistic regression examining predictors of high-risk levels of suicidal ideation.

Total Scores	β	S.E.	Wald	Significance	Exp (B)	95% CI Lower	95% CI Higher
Depression	0.095	0.028	11.825	<0.001 **	1.100	1.042	1.161
Help-seeking	0.010	0.016	0.403	0.525	1.010	0.979	1.043
Quality of life	−0.066	0.022	8.532	0.003 **	0.937	0.896	0.979
Suicide Literacy	−0.044	0.113	0.151	0.698	0.957	0.767	1.195
Hopelessness	0.166	0.082	4.061	0.044 *	1.180	1.005	1.387

* <0.05. ** <0.01.

A logistic regression was also performed to ascertain the effects of previous mental health diagnosis on at-risk SIDAS scores. The overall logistic regression model was statistically significant (c^2 (1) = 186.127, $p < 0.001$), explaining 10.4% of the variation (Nagelkerke R^2). Those with a mental health diagnosis of anxiety were 1.9 times more likely to score $\geq$ 21 on SIDAS ($p = 0.052$). Similarly, students with any diagnosis of a personality disorder were 3.6 times more likely to score $\geq$ 21 ($p = 0.027$). No other predictors were significant.

3.3. Suicidal Thoughts and Behaviours

The final question on the PHQ-9 relates to suicidal thoughts—'thoughts that you would be better off dead'. Nearly half of the sample (n = 220; 48.7%) disclosed they had these thoughts 'nearly every day' in the last two weeks, 19.2% (n = 87) reported having these thoughts 'more than half of the days', and 11.9% (n = 54) reported having these thoughts 'several days'. Only 20.1% of students stated they did not have these thoughts over the time frame (n = 91).

For those who did report having suicidal thoughts in the last two weeks (n = 361), they were asked whether they had a plan to act on these thoughts. 72.3%% (n = 327) had no plans or intent to act upon these thoughts, 15.9% (n = 72) had a rough plan or some intent, and 10.4% (n = 47) had a specific plan or intent. Further analyses revealed a significant association between age and suicidal thoughts (χ (6) = 17.134, $p = 0.009$)—see Table 2.

A logistic regression was performed to identify significant predictors of suicidal thoughts. Overall, the regression model had a good fit (c^2 (1) = 138.013, $p < 0.001$), explaining 33.4% of the variation (Nagelkerke R^2). Depression scores ($p < 0.001$), suicide ideation (SIDAS; $p < 0.001$), and quality of life ($p < 0.001$) were significant predictors of suicidal thoughts. Table 3 provides further details.

Table 2. Rates of reported suicidal thoughts by age.

Age	Not at All (n; %)	Several Days (n; %)	More than Half (n; %)	Nearly Everyday (n; %)
13–14 years (n = 85)	12 (14.1%)	4 (4.7%)	14 (16.5%)	55 (64.7%)
15–16 years (n = 307)	64 (22.6%)	35 (12.3%)	61 (21.5%)	123 (43.4%)
17+ years (n = 89)	15 (17.8%)	15 (17.8%)	12 (14.3%)	42 (49.4%)

Table 3. A logistic regression examining predictors of suicidal thoughts.

Total Scores	β	S.E.	Wald	Significance	Exp (B)	95% CI Lower	95% CI Higher
Depression	0.194	0.028	47.476	<0.001 ***	1.214	1.149	1.283
Help-seeking	−0.003	0.013	0.058	0.809	0.997	0.972	1.023
Quality of life	0.068	0.019	12.342	<0.0001 ***	1.071	1.031	1.112
Suicide Literacy	−0.060	0.096	0.390	0.532	0.942	0.779	1.137
Suicide ideation (SIDAS)	−0.079	0.014	33.817	<0.001 ***	0.924	0.899	0.949
Hopelessness	−0.130	0.082	2.530	0.112	0.878	0.747	1.031

*** <0.001.

3.4. Potential Risk Factors

3.4.1. Suicide Literacy

The mean score for students on the LOSS was 4.46 (SD = 1.40) out of a maximum score of 9 (range = 0–12). Total scores of correct answers in the current sample ranged from 0 (0.2% of the sample) to 8 (1.3%), out of a possible 9. Most commonly, students answered four (28.1% of the sample) or five (28.3%) of the questions correctly. No significant age differences were identified. Individual responses are provided in Appendix A Table A3.

3.4.2. Depressive Symptoms

The mean score for students on the PHQ-9 was 11.10 (SD = 5.91) out of a maximum score of 27 (range = 0–27). This is considered 'moderate' depression. A Spearman's Rank analysis indicated a statistically significant weak, positive correlation between age and depressive scores, with depression scores increasing with age (r_s (452) = 0.101, $p < 0.05$).

3.4.3. Hopelessness

The mean score for students on the Brief-H-Pos was 3.42 (SD = 1.79) out of a maximum score of 10 (range = 0–10), indicating high levels of hopelessness. Almost two-thirds (62.4%; n = 282) disagreed or strongly disagreed with the statement "*the future seems to me to be hopeful and I believe that things are changing for the better*". Similarly, 65.0% (n = 294) disagreed or strongly disagreed with the statement "*I feel that it is possible to reach the goals I would like to stive for*". Further details are provided in Appendix A Table A4. A one-way ANOVA indicated a significant association between age and hopelessness scores, (F (2, 449) = 3.514, $p = 0.031$). Post hoc analyses revealed that 15–16-year-olds were significantly more likely to be hopeful compared to 17+ year olds (0.55 ± 0.21, $p = 0.026$).

3.4.4. Quality of Life

The mean score for students on the CHU9D was 19.87 (SD = 8.04) out of a maximum score of 40 (range = 0–36). Responses to individual items are presented in Appendix A Table A5.

A one-way ANOVA indicated a significant association between age and quality of life scores, (F (2, 449) = 5.927, $p = 0.003$). Post hoc analyses revealed that 13–14-year-olds were significantly more likely to report higher quality of life than 15–16-year-olds (2.52 ± 0.98, $p = 0.029$) and 17+ year olds (4.15 ± 1.22, $p = 0.26$).

3.4.5. Help-Seeking Intentions

The mean score for students on the GHSQ was 16.27 (SD = 10.35) out of a maximum score of 35 (range = 1–33). Most commonly, students said they would seek help from a sibling (mean = 2.81; SD = 1.85) or online (mean = 2.58; SD = 2.06). They were least likely to seek help from a teacher (mean = 1.81; SD = 2.20) or counsellor (mean = 2.13; SD = 2.08).

A one-way ANOVA indicated a significant association between age and help-seeking intentions, (F (2, 449 = 22.59, p <0.001). Post hoc analyses revealed that help-seeking intentions decreased with age; 13–14-year-olds were significantly more likely to seek help than 15–16-year-olds (6.23 $\pm$ 1.22, p = < 0.001) and 17+-year-olds (10.04 $\pm$ 1.52, p = < 0.001), while 15–16-year-olds were more likely to seek help than 17+-year-olds (3.80 $\pm$ 1.23, p = 0.006).

4. Discussion

The current study aimed to explore rates of suicidal ideation and the associated risk factors among female secondary school students in Iraq. Across the current sample, students reported 'moderate' levels of depression and high levels of hopelessness. Students were most likely to seek help from a sibling or online and least likely to seek help from a teacher or counsellor. Quality of life was associated with age, with higher age groups (17+) reporting lower levels of quality of life, compared to 13–14-year-olds. Finally, depression, quality of life and hopelessness significantly predicted suicidal ideation among female students. Adolescent suicidal behaviour is a neglected public health issue, especially in middle- and low-income countries, and there is a greater need for more attention and research exploring suicidal ideation among students in Iraq. Furthermore, females have been shown to be disproportionately affected by suicidal ideation and/or behaviours, with societal factors and pressures placing a bigger burden on female adolescents.

Little research has been done into the mental health of Iraqis; as such, the prevalence of suicidal ideation and associated risk factors requires urgent attention and effective public health initiatives, particularly targeting youth. One national survey conducted in 2007 (Iraq Mental Health Survey; IMHS) [24], with 4332 respondents showed anxiety disorders to be most common (13.8%), followed by major depressive disorder (7.2%). Similar findings were reported in the current study, with the most common mental health diagnosis reported by students being anxiety (42%), followed by depression (22.1%) and obsessive-compulsive disorder (OCD; 16.5%). Given that the IMHS highlighted increasing lifetime prevalence of most disorders across generations, and with individuals younger than 18 years making up almost half the population, addressing the mental health of youth in Iraq is imperative [25].

Over the last two decades, past conflicts, war and economic hostilities have impacted upon the mental health of many Iraqi youth and their families. Exposure to violence, displacement and loss of family have been identified as key factors contributing to poor mental health, in particular PTSD. Research indicates that nearly one in five Iraqi children exhibits symptoms of PTSD, with rates significantly higher in areas most affected by conflict [26]. Furthermore, the ongoing instability and lack of access to mental health services exacerbates these issues, leaving many youths without support [12]. Interestingly, there was no link found between PTSD and mental health in the current study; however, this may be due to the low base rate of students with a PTSD diagnosis. Future research should, therefore, build upon this to further explore the link with PTSD-related symptoms and suicidal ideation among this population.

The current study also highlights high rates of suicidal ideation among Iraqi female secondary school students. Schools provide an important opportunity for suicide prevention and intervention, yet in the current study students disclosed they would be least likely to seek support from teachers. Most teachers in Iraq receive no training on mental health

during their teaching career, and there is a high unmet need for school-based mental health interventions [27]. Students seeking help from siblings or online resources, thus, provides an important avenue to explore, highlighting the specific needs of female students and ensuring the quality and standards of that level of support online is evident to protect those young people seeking support. Despite the obvious need for school-based suicide prevention and mental health intervention, implementing these programmes in Iraq may face significant challenges, including cultural stigma and limited resources [28]. This challenge may further be amplified for female adolescents, who face additional societal pressures surrounding the role of a woman [14]. As such, the existing stigma surrounding suicidal ideation and behaviours is also important to address to better support Iraqi adolescents.

4.1. Limitations

While the current study provides novel insights into the rates of suicidal ideation and associated risk factors of female Iraqi youth, there are some limitations that need to be acknowledged. Firstly, this study examined students across four schools in one area in Iraq, which limits the generalisability of the findings. The sample was relatively small, and while cross-sectional studies are efficient and inexpensive, they have limitations regarding causal inference and temporal relationships, impacting their overall rigor [29]. As the study was conducted between August and December, the shift between season changes may have been associated with changes in mood and the development of Seasonal Affective Disorder (SAD) [30]. Furthermore, the validity of translated measures cannot be assumed, as well as the validity of research findings, since stigma may have been an issue for some Iraqi adolescents when answering questions regarding suicide. Additionally, regression models identified key predictors, such as depression and hopelessness, highlighting their significant roles. However, much variance remains unexplained, which may suggest the involvement of additional psychological, social or contextual factors not captured in the model. This is something future research can explore looking at capturing longitudinal data with more measures to better understand the complexity of suicidal ideation within Iraqi youth. Finally, the lack of PTSD data, despite its known prevalence in conflict-exposed youth in Iraq, limited the findings. Future research should include rigorous research designs, larger sample size and translated psychometric measures that have been validated within Iraqi schools.

Implications for Health and Policy

Findings from the current study highlight the need for mental health education and training, specifically suicide prevention, for school staff, supporting the necessity for and appropriateness of suicide prevention programmes for Iraqi youth. There is an urgent need for a national suicide prevention policy for Iraqi adolescents, particularly females, as well as ensuring appropriate funding allocation for mental health services to ensure access, especially in schools. The stigma around mental health and suicidal ideation, especially for females, is a major barrier to seeking help; thus, public health campaigns are needed to reduce stigma and promote open discussions about mental health. These campaigns should be sensitive to cultural norms but work towards normalising mental health care and encouraging early intervention. Finally, the ongoing conflict, economic instability and past trauma many Iraqi youths have faced has significantly impacted on mental health and suicidal ideation. Policies should, therefore, include specific mental health support for those young people affected by conflict, displacement and family loss, integrating trauma-informed care into both mental health and educational services.

5. Conclusions

The current study explored rates of suicidal ideation and associated risk factors among female secondary school students in Baghdad, Iraq, a previously overlooked public health concern, particularly among low and middle-income countries. Findings reveal that Iraqi secondary school students experience moderate levels of depression and high levels of hopelessness, both of which are significant predictors of suicidal ideation. The reluctance of students to seek help from teachers emphasises the importance of developing targeted school-based interventions to support young people's mental health. Increasing research and attention in this area is vital to not only improving the mental health of students in Iraq but also reduce the stigma around mental health and suicide.

Author Contributions: S.S.A., A.M.F. and H.A.S.A. were responsible for data acquisition. S.S.A., P.S., E.A. and A.S.A. designed the study with input from all authors. P.S., E.A., M.M. and J.R. were responsible for analysis and interpretation. M.M. and E.A. provided statistical advice in the analysis and interpretation of data. M.M., E.A. and P.S. drafted the manuscript and S.S.A., A.M.F., H.A.S.A., A.S.A., D.A.-J., S.N. and J.R. helped to revise the paper. S.S.A., A.M.F. and H.A.S.A. had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. S.S.A. and A.S.A. verified the data. P.S. and E.A. were jointly responsible for the final decision to submit for publication. Future work should include adapting international school-based prevention models to the Iraqi context. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Imam Ja'afar Al-Sadiq University, College of Arts Ethical Approval Committee on 15th August 2023 (Ref: 2023-01).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study and their parents.

Data Availability Statement: The datasets generated and/or analysed during the current study will be made available at https://dese.ai/medicaldatabank/ (accessed on 21 January 2025).

Acknowledgments: The authors thank the hard work of the researchers who contributed to the data collection and the analysis, as well as the schools and students who took part in the study. The authors have declared that they have no competing or potential conflicts of interest.

Conflicts of Interest: The authors declare no conflict of interest.

Appendix A

Table A1. Reported diagnosis rates of mental health and neurodivergent conditions.

Mental Health Diagnosis	Yes (n)	No (n)
Depression	99 (21.9%)	353 (78.1%)
Anxiety	190 (42%)	262 (58%)
Bipolar	14 (3.1%)	438 (96.9%)
OCD	77 (17.0%)	375 (83.0%)
Anorexia	40 (8.8%)	412 (91.2%)
Bulimia	11 (2.4%)	441 (97.6%)
Any Personality Disorder	21 (4.6%)	431 (95.4%)
PTSD	25 (5.5%)	427 (94.5%)
Substance Use	1 (0.2%)	451 (99.8%)
Psychotic Disorder	22 (4.9%)	430 (95.1%)
ADHD	50 (11.9%)	402 (88.9%)
Autism	9 (2.0%)	443 (98.0%)
None	99 (21.9%)	353 (78.1%)

Table A2. Individual item responses on the SIDAS (0 = Never, 10 = Always).

0	1	2	3	4	5	6	7	8	9	10
In the past month, how often have you had thoughts about suicide?										
265 (58.6%)	53 (11.7%)	24 (5.3%)	23 (5.1%)	29 (6.4%)	10 (2.2%)	7 (1.5%)	11 (2.4%)	5 (1.1%)	6 (1.3%)	19 (4.2%)
In the past month, how much control have you had over these thoughts?										
228 (50.4%)	26 (5.8%)	14 (3.1%)	13 (2.9%)	10 (2.2%)	16 (3.5%)	9 (2.0%)	11 (2.4%)	14 (3.1%)	17 3.8%)	94 (20.8%)
In the past month, how close have you come to making a suicide attempt?										
331 (73.2%)	39 (8.6%)	23 (5.1%)	15 (3.3%)	11 (2.4%)	7 (1.5%)	3 (0.7%)	3 (0.7%)	5 (1.1%)	0	15 (3.3%)
In the past month, to what extent have you felt tormented by thoughts about suicide?										
303 (67.0%)	45 (10.0%)	19 (4.2%)	20 (4.4%)	11 (2.4%)	10 (2.2%)	6 (1.3%)	16 (3.5%)	2 (0.4%)	1 (0.2%)	19 (4.2%)
In the past month, how much have thoughts about suicide interfered with your ability to carry out daily activities, such as work, household tasks or social activities?										
285 (63.1%)	79 (17.5%)	7 (1.5%)	4 (0.9%)	10 (2.2%)	25 (5.5%)	7 (1.5%)	6 (1.3%)	5 (1.1%)	3 (0.7%)	21 (4.6%)

Table A3. Responses to individual items on the LOSS.

	True (T)—1	False (F)
1–0 "Most people who die by suicide are younger than 30" (F)	156 (34.5%)	296 (65.6%)
2–1 "Men are more likely to die by suicide than women" (T)	302 (66.80%)	149 (33.0%)
3–1 "People who want to attempt suicide can change their mind quickly" (T)	208 (46.0%)	243 (53.8%)
4–0 "Media coverage of suicide will influence other people to attempt suicide" (F)	168 (37.2%)	284 (62.8%)
5–0 "Everyone who dies by suicide would be diagnosed as depressed" (F)	201 (44.5%)	251 (55.5%)
6–0 "Talking about suicide always increases the risk" (F)	184 (40.7%)	268 (59.3%)
7–1 "A suicidal person will not always be suicidal" (T)	147 (32.5%)	305 (67.5%)
8–1 "Seeing a health professional can prevent suicide" (T)	130 (28.8%)	322 (71.2%)
9–1 "You don't have to be a professional to help someone who is suicidal" (T)	279 (61.7%)	173 (38.3%)

Table A4. Responses to individual items on the Brief-H-Pos.

	Absolutely Disagree	Somewhat Disagree	Cannot Say	Somewhat Agree	Absolutely Agree	Missing Data
"The future seems to me to be hopeful and I believe that things are changing for the better"	234 (51.8%)	48 (10.6%)	58 (12.8%)	12 (2.7%)	11 (2.4%)	89 (19.7%)
"I feel that it is possible to reach the goals I would like to strive for"	233 (51.5%)	61 (13.5%)	44 (9.7%)	106 (23.5%)	6 (1.3%)	2 (0.4%)

Table A5. Responses to individual items of the CHU9D.

	I Don't Feel/I Had No Problems with...	**I Feel a Little Bit/I Had a Few Problems with...**	**I Feel a Bit/I Had Some Problems with...**	**I Feel Quite/I Have Many Problems with...**	**I Feel Very/I Can't...**
Worried	77 (17.0%)	65 (14.4%)	81 (17.9%)	86 (19.0%)	143 (31.6%)
Sad	82 (18.1%)	121 (26.8%)	65 (14.4%)	82 (18.1%)	102 (22.6%)
In pain	69 (15.3%)	33 (7.3%)	54 (11.9%)	83 (18.4%)	213 (47.1%)
Tired	111 (24.6%)	160 (35.4%)	57 (12.6%)	71 (15.7%)	52 (11.5%)
Annoyed	151 (33.4%)	42 (9.3%)	72 (15.9%)	81 (17.9%)	106 (23.5%)
Completing school work/homework	45 (10.0%)	59 (13.1%)	76 (16.8%)	96 (21.2%)	176 (38.9%)
Sleeping	100 (22.1%)	136 (30.1%)	41 (9.1%)	69 (15.3%)	106 (23.5%)
Completing my daily routine	30 (6.6%)	30 (6.6%)	139 (30.8%)	71 (15.7%)	182 (40.3%)
Joining in activities	76 (16.8%)	132 (29.2%)	54 (11.9%)	73 (16.2%)	117 (25.9%)

References

1. World Health Organization. Preventing Suicide: A Global Imperative. WHO. 2020. Available online: https://www.who.int/publications/i/item/9789241564779 (accessed on 29 October 2024).
2. Abbas, M.J.; Alhemiary, N.; Razaq, E.A.; Naosh, S.; Appleby, L. The Iraqi national study of suicide: Report on suicide data in Iraq in 2015 and 2016. *J. Affect. Disord.* **2018**, *229*, 56–62. [CrossRef] [PubMed]
3. Office of National Statistics (ONS). Suicides in the UK: 2017 Registrations. 2022. Available online: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations (accessed on 13 April 2025).
4. World Health Organisation [WHO]. Iraq—WHO Data. 2024. Available online: https://data.who.int/countries/368 (accessed on 13 April 2025).
5. Iraqi Ministry of Heath (Ed.) *The Annual National Health Statistics Report*; Iraqi Ministry of Heath: Baghdad, Iraqi, 2016.
6. Younis, M.S.; John, A. Insight of suicide in Iraq: A coroner's report. *Middle East Curr. Psychiatry* **2023**, *30*, 55. [CrossRef]
7. Younis, M.S.; Lafta, R.K. Suicide and suicidality in Iraq: A systematic review. *Med. Confl. Surviv.* **2023**, *39*, 48–62. [CrossRef]
8. Whiting, D.; Lichtenstein, P.; Fazel, S. Violence and mental disorders: A structured review of associations by individual diagnoses, risk factors, and risk assessment. *Lancet Psychiatry* **2021**, *8*, 150–161. [CrossRef] [PubMed]
9. World Health Organisation, Eastern Mediterranean Region (WHO-EMRO). An Increasing Number of Suicide Cases in Iraq Worries Public Health Experts Amid COVID-19 Pandemic. 2020. Available online: https://www.emro.who.int/iraq/news/an-increasing-number-of-suicide-cases-in-iraq-worries-public-health-experts-amid-covid-19-pandemic.html (accessed on 13 April 2025).
10. Saied, A.A.; Ahmed, S.K.; Metwally, A.A.; Aiash, H. Iraq's mental health crisis: A way forward? *Lancet* **2023**, *402*, 1235–1236. [CrossRef]
11. Ahmed, D.R. Mental health problems in Iraq: A systematic review. *Glob. Psychiatry Arch.* **2022**, *5*, 26–35. [CrossRef]
12. Razokhi, A.H.; Taha, I.K.; Taib, N.I.; Sadik, S.; Al Gasseer, N. Mental health of Iraqi children. *Lancet* **2006**, *368*, 838–839. [CrossRef]
13. Benoni, R.; Giacomelli, C.; Vegro, G.; Hamo, F.; Avesani, R.; Albi, P.; Gatta, M.; Moretti, F. Assessing the mental health needs of Yazidi adolescents and young adults in an Iraqi Kurdi IDP Camp: A focus group study. *Int. J. Equity Health* **2024**, *23*, 88. [CrossRef]
14. Vijayakumar, L.; Lamech, N. *Suicide and Suicidal Behavior in Women*; Mental Health and Illness of Women; Springer: Singapore, 2020; pp. 35–56.
15. Al-Hamzawi, A.O.; Bruffaerts, R.; Bromet, E.J.; AlKhafaji, A.M.; Kessler, R.C. The epidemiology of major depressive episode in the Iraqi general population. *PLoS ONE* **2015**, *10*, e0131937. [CrossRef]
16. Van Spijker, B.A.; Batterham, P.J.; Calear, A.L.; Farrer, L.; Christensen, H.; Reynolds, J.; Kerkhof, A.J. The Suicidal Ideation Attributes Scale (SIDAS): Community-based validation study of a new scale for the measurement of suicidal ideation. *Suicide Life-Threat. Behav.* **2014**, *44*, 408–419. [CrossRef]
17. Kroenke, K.; Spitzer, R.L.; Williams, J.B. The PHQ-9: Validity of a brief depression severity measure. *J. Gen. Intern. Med.* **2001**, *16*, 606–613. [CrossRef] [PubMed]

18. Fraser, L.; Burnell, M.; Salter, L.C.; Fourkala, E.O.; Kalsi, J.; Ryan, A.; Gessler, S.; Gidron, Y.; Steptoe, A.; Menon, U. Identifying hopelessness in population research: A validation study of two brief measures of hopelessness. *BMJ Open* **2014**, *4*, e005093. [CrossRef] [PubMed]
19. Olivari, C.; Guzmán-González, M. Validation of the general help-seeking questionnaire for mental health problems in adolescents. *Rev. Chil. Pediatr.* **2017**, *88*, 324–331. [CrossRef] [PubMed]
20. Stevens, K.; Ratcliffe, J. Measuring and valuing health benefits for economic evaluation in adolescence: An assessment of the practicality and validity of the child health utility 9D in the Australian adolescent population. *Value Health* **2012**, *15*, 1092–1099. [CrossRef]
21. Calear, A.L.; Batterham, P.J.; Trias, A.; Christensen, H. The literacy of suicide scale. *Crisis* **2022**, *43*, 385–390. [CrossRef]
22. Armstrong, R.A. When to use the B onferroni correction. *Ophthalmic. Physiol. Opt.* **2014**, *34*, 502–508. [CrossRef]
23. Rothman, K.J. No adjustments are needed for multiple comparisons. *Epidemiology* **1990**, *1*, 43–46. [CrossRef] [PubMed]
24. Bolton, P. Mental health in Iraq: Issues and challenges. *Lancet* **2013**, *381*, 879–881. [CrossRef]
25. World Health Organisation (WHO). Mental Health of Adolescent. 2021. Available online: https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health (accessed on 13 April 2025).
26. Al-Gasseer, N.; Dresden, E.; Keeney, G.B.; Warren, N. The Impact of Armed Conflict on Children's Mental Health: A Case Study from Iraq. *J. Child Adolesc. Psychiatr. Nurs.* **2016**, *29*, 45–54. [CrossRef]
27. Al-Obaidi, A.K.; Nelson, B.D.; Al Badawi, G.; Hicks, M.H.R.; Guarino, A.J. Child mental health and service needs in Iraq: Beliefs and attitudes of primary school teachers. *Child Adolesc. Ment. Health* **2013**, *18*, 171–179. [CrossRef]
28. Baghian, N.; Shati, M.; Akbari Sari, A.; Eftekhari, A.; Rasolnezhad, A.; Nanaei, F.; Ahmadi, B. Barriers to Mental and Social Health Programs in Schools: A Qualitative Study. *Iran. J. Psychiatry* **2023**, *18*, 97–107. [CrossRef] [PubMed]
29. Maier, C.; Thatcher, J.B.; Grover, V.; Dwivedi, Y.K. Cross-sectional research: A critical perspective, use cases, and recommendations for IS research. *Int. J. Inf. Manag.* **2023**, *70*, 102625. [CrossRef]
30. Zhang, R.; Volkow, N.D. Seasonality of brain function: Role in psychiatric disorders. *Transl. Psychiatry* **2023**, *13*, 65. [CrossRef] [PubMed]

healthcare

MDPI

Perspective

Is Life Unlivable for Youth in Post-DEI America?: Understanding Rising Suicide Rates Across Diverse Youth Groups Through Traditional Suicide Paradigms

Mimi Yen Li *, Christina Mata and Kalpana Nathan

Department of Psychiatry and Behavioral Sciences, University of California, San Francisco, CA 94107, USA; christina.mata@ucsf.edu (C.M.); knathan@stanford.edu or kalpana.nathan@ucsf.edu (K.N.)
* Correspondence: mimi.yenli@ucsf.edu

Abstract

We pose the question of whether life has become unlivable for the young in America amidst the current political climate, which has systematically deregulated our social structures that safeguard against oppressive and unjust practices. What leads the young to become demoralized to the point of wanting to end their lives? Drawing on several established psychosocial models for suicide, including those of Durkheim, Joiner, and Butler, we highlight how groups of youth as disparate as youth of color, LGBTQ+ youth, and young men experience unique sociopolitical stressors that contribute to increased suicidality. We argue that despite differences in their contexts, they experience shared pathways to suicide. At a time when U.S. funding cuts threaten to dismantle the progress made in recent years to address structural racism and sexism, we also make a case for the importance of mental health clinicians' engagement in advocacy work that recognizes the sociopolitical influences on mental health and highlight universal school-based social emotional learning (USB SEL) as one beneficial intervention to target mental health outcomes across disparate youth groups.

Keywords: suicide; adolescent; DEI; livability; LGBTQ+; youth of color; incels

1. Introduction

Youth suicide is a major public health concern globally and is the third leading cause of death among 15 to 29-year-olds [1]. In the United States, suicide is the second leading cause of death among 10 to 19-year-olds, and one in five youth have reported seriously contemplating suicide [2,3]. Suicide deaths among 10 to 24-year-olds in America increased by 62% from 2007 to 2021; they have also risen dramatically in American preteens as young as 8 years old, with an 8.2% annual increase from 2008 to 2022 [4]. High suicide rates are found in subsets of youth as diverse as LGBTQ+ youth, youth of color, and young men. The prevalence of despair in youth is similarly high, with significant disparities by race, sex, and gender identity. In 2024, the CDC reported that 40% of high school students reported persistent feelings of sadness or hopelessness during the past year. This was higher in females (53%) than males (28%); higher among LGBTQ+ (65%) than cisgender and heterosexual (31%) individuals; highest among American Indian or Alaskan Native (45%), Hispanic (42%), multiracial (41%), Black (40%), White (39%), and Asian (32%) individuals; and lowest among Native Hawaiian or Pacific Islanders (26%) [3,5].

We share our perspective as psychiatrists practicing in San Francisco, long hailed as a city championing social activism and compassionate ethos, where progress made over

the decades is being toppled at an alarming rate. The current Trump administration has ushered in what might be considered a post-DEI era, enacting numerous executive orders, leading to the dismantling of diversity, equity, and inclusion (DEI) efforts, restrictions on gender affirming care, reversal of transgender policies, deportation and detention of immigrants, and rollback of research funding and health insurance coverage [6–8]. We know that self-harm rates are worse in marginalized groups such as youth of color and LGBTQ+ adolescents, but we are losing funding to both study and treat these populations, as a loud and powerful majority center White men as perceived victims [9,10]. As resentment against marginalized groups mounts and the narrative of victimhood becomes increasingly universalized, we explore why different groups, regardless of their identity, might see themselves as vulnerable and ostracized. We highlight how groups of youth as disparate as youth of color, LGBTQ+ youth, and young men experience unique sociopolitical stressors that contribute to increased suicidality. We argue that despite differences in their contexts, they experience shared pathways to suicide. Of note, we do not discuss intersectionality in the scope of our paper but recognize this is an important consideration that must be explored. In response to regressive policies that strip away resources from marginalized groups, we propose that mental health professionals must not only advocate for protective policies but also collaborate with the education and public health sectors to strengthen programs such as the Social Emotional Learning curriculum, which is foundational in building a nurturing school climate.

2. Theoretical Frameworks for Understanding Suicide

There have been dramatic shifts over the years in how society has viewed suicide, from the older religious perspective that taking one's own life is a sin to the current day's strong influence of the psychological model, which purports that mental illness is the primary cause, the so-called "90 percent statistic" [11]. In ancient Rome, some forms of self-killing were considered honorable, with the Epicureans acknowledging that one had the right to dispose of their own life. Laws permitted self-killing for a variety of reasons, including *taedium vitae* (one has had enough of life), *inpatientia* (bodily suffering), *dolor* (psychic pain), and *pudor* (shame) [12,13]. In 1897, Durkheim proposed that the root cause of suicide might be underlying social conditions, which heralded the move away from the religious belief that condemned it to be a moral crime. He proposed four different types of suicide based on the lack or abundance of social integration and moral regulation: egoistic suicide, altruistic suicide, anomic suicide, and fatalistic suicide [13–16]. Joiner talks about "thwarted belonging," also in the context of isolation and non-integration, as a cause for suicide [17]. While it is considered in suicidology to be a well-established fact that 90% of all suicides are a consequence of mental disorders, Hjelmeland and Knizek argue that, in addition to psychiatric conditions, one has to focus on the contextual and the relational in the life course perspective to fully understand the nature of suicide [18]. There have been many theories to better understand suicidal thoughts and behaviors, but predictive ability has not improved despite a half-century of risk factor research [19]. There is no simple solution to decrease suicidality and increase mental well-being across a wide range of youth groups, yet ongoing research and theories are critical to refining and developing intervention and prevention efforts. A cohesive way to approach how diverse groups experience mental health challenges is to understand the social determinants of mental health, an approach that is aligned with Durkheim and Joiner's views that the sociopolitical context is inextricably tied to suicide.

3. Sociopolitical Forces Eroding Belonging in Disparate Youth Groups

Cover elegantly puts together a narrative for rethinking minority youth suicide, drawing upon themes of loneliness, isolation from the works of Durkheim and Joiner, and Butler's approach to social belonging, livability, and grievability [20]. Butler defines livability as sociopolitical, economic, institutional, biological, and psychological conditions that enable a life of meaning rather than mere existence, while unlivability is characterized by a loss of these vital conditions, leading to extreme suffering and injustice. When one is faced with an unlivable life, life may not feel worth safeguarding, protecting, or valuing, hence not worth grieving or "ungrievable" [21]. Rather than viewing isolation and loneliness as the root causes of suicide, Cover articulates that they may be reconceptualized as contributions to unlivability [20]. Together, these frameworks suggest that disparate populations may face suicide risk via common pathways toward an "unlivable life," which may be paved by sociopolitical conditions that erode belonging, deprive resources for basic needs, or impose persecution.

3.1. Youth of Color

The suicide rate among American Black youth between 10 to 17 years old increased by 144% between 2007 and 2020, significant for being the fastest-growing rate among racial groups [22]. Joseph and colleagues showed that from 1999 to 2020, suicide rates among Black females aged 15 to 84 increased from 2.1 to 3.4 per 100,000, with a concentrated rate increase from 1.9 to 4.9 per 100,000 among those aged 15 to 24. They utilized age, period, and cohort (APC) effects to elicit key information, which helped with more precise identification of the concentration of suicide risk for young Black women in the US [23].

The sociopolitical context has had a marked impact on suicide rates among youth of color in the United States. Structural factors such as racism, concentrated poverty, and economic segregation are strongly associated with suicide risk [24,25]. The CDC's Youth Risk Behaviors Survey from 2023 found that students who experienced racism had a higher prevalence of indicators of poor mental health, substance use, and suicide risk. Among students of color, including American Indian or Alaska Native, Asian, Black, Hispanic, and multiracial students, those who experienced racism had two times higher prevalence of seriously considering and attempting suicide compared with those who never experienced racism [26,27]. Moreover, this group's disparities in access to healthcare and education may be further exacerbated by disproportionate representation of youth of color in the foster care and juvenile incarceration systems, settings known to be associated with higher suicide risk [28,29]. Beyond systematic forms of racism, many American youth of color experience insidious forms of discrimination in daily life, such as through online racial discrimination on social media; these forms of racism are also associated with increased suicidal ideation among Black and Latinx youth [30–32].

Recent sweeping policy changes from the current administration have compounded an already vulnerable social foundation. Executive orders terminating diversity, equity, and inclusion (DEI) programs and initiatives have unilaterally retracted critical programs that ameliorated inequities for minoritized youth and halted research documenting race- and ethnicity-disaggregated research on mental health outcomes for particular minoritized groups [33]. Moreover, the administration's targeting of news outlets, suppression of dissent, threats of funding cuts to academic institutions for DEI efforts, and aggressive enforcement of anti-immigration policies have exerted a "chilling effect" on minoritized Americans [34–37]. These executive orders codify the erasure of youth of color from public and academic awareness, withdraw resources, and mechanize discrimination, all factors that contribute to suffering, injustice, and unlivability.

3.2. LGBTQ+ Youth

Mental health challenges and suicidality are significant concerns for LGBTQ+ youth, a population that has its own unique history and sociopolitical context. It is important to understand the underlying role stigma and minority stress play in determining mental health disparities among LGBTQ+ youth. Meyer posited the minority stress theory in 2003, by which individuals from stigmatized social categories are exposed to excess stress as a result of their social and often minoritized position [38,39]. These unique stressors go beyond the general stressors that are experienced by all individuals in that they are both socially based and chronic throughout one's lifetime, given their perpetuation through laws and policies. Therefore, any discussion of mental health challenges present in LGBTQ+ youth must acknowledge that the presence of these challenges is significantly impacted by targeted stigma operating on an individual, interpersonal, and structural basis.

On an individual level, internalized homophobia and transphobia, which refer to the internalization of negative societal attitudes about one's sexual orientation and gender identity, can lead to unhealthy behaviors and poor mental health outcomes among LGBTQ+ individuals. For example, Perez-Brumer et al. show internalized transphobia is associated with increased risk of lifetime suicide attempts among transgender adults [39]. Another example of the impact of stigma on the individual level is rejection sensitivity. As a consequence of previous experiences with prejudice and discrimination toward their LGBTQ+ group membership, many individuals learn to anxiously anticipate rejection and develop unhealthy coping strategies as a result [40].

Perhaps one of the most salient examples of interpersonal stigma leading to poor mental health outcomes in LGBTQ+ youth is bullying and victimization. To draw from data reflecting another Western country, in British LGBTQ+ youth, bullying and online bullying have been shown to be correlated with self-harm and suicidal ideation [41]. In 2024, the Trevor Project reported that nearly half of LGBTQ+ teenagers in the US experienced bullying and demonstrated higher rates of suicide attempts than their counterparts who did not experience bullying [42]. Jadva et al. found that nearly 17% of UK adolescents who experienced more homophobic, biphobic, and transphobic (HBT) bullying were more likely to report self-harm and suicidal ideation, while 20% were more likely to report a suicide attempt. These results are even stronger with regard to online bullying, with adolescents who experienced online bullying being 25% more likely to report self-harm and suicide ideation and 22% more likely to report a suicide attempt [41].

The Trump administration ushered in America's post-DEI era, enacting numerous executive orders rolling back DEI initiatives and suppressing recognition of gender and sexual minorities, amplifying negative structural effects on LGBTQ+ mental health. Recent cuts in federal funding for public health care have jeopardized targeted resources for minoritized populations, such as the discontinuation of the LGBTQ+ youth suicide hotline on 17 July 2025 and limitations on gender affirming care. Given limited data on these very recent changes on federal, state, county, and city levels, only an anecdotal discussion based on clinical and academic experiences can be shared. As recently as Spring 2025, the academic clinical staffing within our city's LGBTQ+ clinic serving publicly-insured patients was severely cut as a result of shifting national and state funding contracts. As a result of these political shifts, both public and private clinics serving LGBTQ+ identifying patients across the California Bay Area have seen exacerbations in mental health symptoms, from depression and anxiety to trauma and gender dysphoria. These symptom exacerbations have been experienced in waves that correlate with social and political discourse centered on sexual and gender identity and threats to their legal protections. Some states like California are stepping up to fill the gap, but without federal support, our nation will face a patchwork quilt of mental health care policy deserts for minoritized youth [43]. As such,

discriminatory policies systematize structural stigma and inevitably undermine public mental health [44].

3.3. Young Men and Boys

The sociopolitical context of young men and boys has shifted drastically in the last several decades. Economically, technological advances in job automation have decreased well-paying manufacturing and manual labor work that were predominantly occupied by men; these trends are likely to be ongoing with the spread of generative artificial intelligence technology. The COVID-19 epidemic additionally exacerbated economic pressures, diminished social ties, and negatively impacted civic and social communities. These changes intersect with gendered norms such as R.W. Connell's conception of hegemonic masculinity, which emphasizes stoicism, toughness, and control [45]. These norms socialize boys and men to suppress emotional vulnerability, which in turn reduces help-seeking behaviors for depression, anxiety, and suicidal ideation [46]. Young men find themselves in the "double bind" of masculinity, where conforming to masculine norms leaves them bereft of care, but eschewing these norms alienates them from their peers [47]. These shifts have led to significant declines in mental health outcomes for young men.

In 2023, the suicide rate among American men was nearly four times higher than women, accounting for 80% of all suicides [48]. Explanations for the suicide rate disparity between men and women have been hypothesized to be related to the higher lethality methods that men are more likely to employ (e.g., hanging, asphyxiation, and by firearm). Other possible reasons for high-lethality behavior in males may be: a stronger intent to die, a greater threshold for help-seeking, social isolation with a lower likelihood of being rescued, more aggressive personality traits, the involvement of alcohol, and the significant role of unemployment [49]. Young men are increasingly facing disconnection from educational, employment, civil, and social life. Compared to women, men in the US face higher unemployment rates and have seen a precipitous drop in college enrollment and completion over the last decade, with over 10% of men between the age of 25 and 54 neither working nor in school. Unemployment, lack of a college education, and financial hardship are all respectively associated with triple, quadruple, and quintuple the odds of suicide attempts [50–54]. Data from a population-wide study in Germany showed that nearly a quarter of men report social isolation, both through objective metrics such as living alone and being unmarried and subjective reports of loneliness [55]. These compounding factors of unemployment, reduced education, and increased loneliness drive the majority of suicides in young men [55,56].

This erosion of social and civic connection coincides with a broader shift toward life online, where American youth aged 8 to 18 now spend an average of 7.5 h per day on digital platforms [57]. For many young men, loneliness and disconnection increase susceptibility to online radicalization. Research links vulnerability to extremism with lower levels of social capital, and extremist online communities show a high concentration of mental health difficulties [58]. The involuntary celibate ("incel") community offers a stark example.

The term "involuntary celibate" was originally coined by a Canadian female undergraduate student in 1997. It was then adopted by a group of heterosexual men who coalesced around their frustration from romantic rejection and pointed to several perceived causes of this rejection, which ranged from their own physical appearances to larger societal movements such as feminism. This online subculture first emerged on Reddit, with 40,000 active members before it was banned in 2017; online membership then moved to numerous other platforms such as 4chan, 8chan, and privately encrypted platforms such as Telegram and Discord. Since then, the incel community has radicalized significantly, adopt-

ing extremist ideologies including misogyny, racism, and in rare cases, terrorism. Emerging research demonstrates that factors such as social alienation, perceived lack of social mobility, algorithm-driven dating technology, and online echo chambers have heightened mating market competition and engendered hopelessness, both of which are associated with increased suicidal ideation [59–63].

Increasingly, studies point to a significant burden of mental health challenges in the incel community. Despite public perception, most incels do not engage in violence. Exploratory studies show incels report a high prevalence of being bullied, greater rejection sensitivity, a greater fear of being single, and lower levels of self-esteem and secure attachment than their male counterparts. Incels' self-reported prevalence of depression and anxiety is as high as 95% and 94%, respectively; in comparison, a representative sample of American adults reported a prevalence of depression and anxiety of 28% and 35% to the CDC in 2020 [64,65]. Only about half of incels have reported engaging in psychotherapy but are ten times less likely to report benefit from it compared to the majority of American adults who have engaged in psychotherapy [60,64–66].

The incel community exhibits a complex relationship with suicidality, in which high baseline vulnerability is compounded by online discourse that both offers support and normalizes self-harm. Within incel forums, an analysis of 80 suicide posts by incels, Daly and Laskovstov found that incel communities were complex in their dual role as a support for lonely and hopeless incels and also sometimes as pro-suicide spaces where "roping" was encouraged [67]. While this particular community may find themselves holding demographic markers with higher social capital (cis-gendered men, heterosexual, predominantly Caucasian), the discussion above demonstrates how loneliness and hopelessness may drive their radicalization and subsequent poor mental health outcomes.

4. Shared Pathways Toward Suicidality

Although the contexts of youth groups as disparate as youth of color, LGBTQ+ youth, and young men feature distinct histories and sociopolitical pressures, their pathways toward suicidality converge along several shared mechanisms. When one considers Joiner's ideas of "thwarted belonging," these groups of youth demonstrate social alienation through the influences of racism, homophobia, bullying, and in the disconnection from social communities and meaningful relationships. In an effort to better understand the increase in self-harm tendencies in sexual minorities, the psychological factors such as self-esteem and thwarted belongingness have been shown to have a greater association, and may be helpful in directing preventative and interventional efforts [68,69]. Butler's description of the "precariousness" of life and argument that sustaining a "livable" life necessitates affirming socio-economic and political conditions is evident through the transformative and injurious effects of the COVID-19 epidemic and recent systematic national policies ossifying race-, sex-, and gender-based discrimination. In 2022, Case and Deaton echoed Butler's ideas when they coined the term "deaths of despair" to describe the connection between the deterioration of life for many White male Americans and rising deaths from substance use overdoses and suicide in the latter part of the 20th century [70]. Their selective and narrow depiction of these deaths as disproportionately affecting White men led Trump's first-term administration to focus on opioid use disorder treatment efforts, but in ways that predominantly served White Americans [71]. There have been many reports that have refuted this data, including Muennig and colleagues, who offer a more expansive and enduring narrative of the opioid crisis that highlights deaths of despair are "neither a recent problem nor is it confined to Whites." Their work identifies disturbing trends in declining relative life expectancy in the United States and is part of a large body of literature connecting this excess mortality from despair to suicidality [72].

The ideas of these thinkers and researchers highlight the inherent interconnectedness of our lives to each other and to the sociopolitical environments we live in. While it may be unconventional to draw parallels between these disparate groups of youth, their shared end outcomes of increased rates of self-harm and suicidality, in part brought about by isolation and loneliness, exemplify Butler and Cover's "unlivability" of life.

5. Recommendations and Next Steps

The intersubjective conditions of a livable life in the world imply a social and ethical obligation toward the life of the other [21]. When the social fabric supporting those with limited resources is stripped, and a government no longer honors obligations to those who need it the most, advocacy work to nurture the conditions that sustain life becomes even more vital.

Amelioration of upstream factors like poverty, for example, is correlated with declines in suicide risk, highlighting the necessity of addressing the sociopolitical context in efforts to reduce suicide risk in youth [24]. In the current American sociopolitical landscape, it is also important to recognize how policy and funding changes will limit our ability to formally study the mental health outcomes in youth of color and LGBTQ+ youth and sustain dedicated clinical spaces for their treatment. Mental health professionals can act by advocating for reforms in public policies and for changes in social norms. Shim and Compton posed the question, "If not now, when? If not us, who?" in 2020 with an urgency that is even more relevant today [73].

5.1. Policy Advocacy

Mental health clinicians are in a unique position to advocate for a myriad of policies that support public mental health. As administrative executive orders terminate DEI and gender equity and sexual identity inclusiveness initiatives across industry, schools, and healthcare, essentially codifying structural discrimination, it becomes increasingly vital that mental health clinicians engage in political advocacy work against such oppressive policies. The links between discriminatory policies and worse mental health outcomes cannot be ignored. For example, English and colleagues conducted an analysis showing states with more indicators of structural racism (e.g., residential segregation, incarceration rates, and educational attainment) and anti-LGBTQ+ policies (e.g., HIV criminalization, conversion therapy, and permitting hate crimes) are associated with suicide risk factors such as depressive symptoms, perceived burdensomeness, thwarted belongingness, and suicide attempts in young Black sexual minority men [74].

Just as one might prescribe therapy or pharmacotherapy to treat a mood disorder, interventions such as anti-discrimination policies have been shown to protect mental health outcomes [44]. For example, state policies that protect gender-diverse people have been associated with decreased discrimination against and reduced rates of suicidality in gender-minority individuals living in those states [75,76]. Similarly, interventions to improve the mental health of youth of color in the United States must address the underpinnings of racism within healthcare, disparities in access to quality mental health care, housing and education inequities, and the disproportionate funneling of youth of color into the U.S. incarceration system [77]. For example, investments in interventions such as multisystemic therapy, an intensive community- and family-based therapy modality which addresses risk factors across family, peer, school, and community contexts, have demonstrated reductions in recidivism and mental health issues, and improved functioning for juvenile justice involved youth [78–80].

The high suicide rates of young men also necessitate policies that target the reconnection of this large group of youth to schools, work, and relationships. Several states

have begun to recognize this. For example, this year, the Governor of California signed an executive order addressing the "growing crisis of connection and opportunity for men and boys" [81]. Such orders are a first step to generate pathways for youth to enter education, civic life, and the workforce, expand access to mental health care, and recruit positive role models into positions of mentorship for young men.

5.2. Education

Considering the above discussion on individual, interpersonal, and structural stigma and their role in precipitating poor mental health outcomes, we advocate for interventions centered within the education sector that could target all three levels. Given the existing, large-scale implementation of universal school-based social emotional learning (USB SEL), mental health clinicians have a unique opportunity for collaboration to better tailor these curricula to target outcomes such as self-harm and suicidal ideation present across the youth groups discussed above. USB SEL has the potential for large-scale impact not only due to its universal implementation across many schools around the country but also because of its ability to teach youth core concepts within psychoeducation.

Fricker introduced the concept of epistemic injustice, which included testimonial injustice (unjust deficit of credibility owing to prejudice) and hermeneutical injustice (one's inability to give meaning and/or communicate their experience because their marginalized social group lacks the collective conceptual resources to interpret it) [82]. When one considers the idea of epistemic uncertainty—that a lack of knowledge about a situation or system gives rise to uncertainty within an individual and limits their ability to verbalize their experience—it is clear that helping youth understand their internal mental health experiences could increase their ability to access care and reduce their isolation. Encouraging skill building in this arena from an early age through school is a powerful way to encourage youth to develop the self-knowledge and communication skills for a livable and connected life [83].

USB SEL interventions are designed to support the development of intrapersonal and interpersonal skills to promote psychological health for all students in a given school or grade. Cipriano and colleagues' meta-analysis of over 400 studies of USB SEL found that students who participated in USB SEL interventions experienced statistical improvement in school climate and safety, civic attitudes and behaviors, SEL skills, peer relationships, attitudes and beliefs, prosocial behaviors, externalizing behaviors, emotional distress, school functioning, and academic achievement [84]. These outcomes are particularly bolstering for the role of USB SEL when one considers UK-based data that adolescents who reported a more positive school experience were 40% less likely to report self-harm or suicide attempts and 65% less likely to report suicidal ideation [41]. Across disparate groups of youth, further development and improvement of peer relationships, emotional distress, and prosocial behaviors could benefit their mental health outcomes.

One example of potential collaboration could be the incorporation of the findings from Brennan et al.'s systematic review and thematic meta-synthesis into the appropriate USB SEL skill teachings [85]. Brennan and colleagues identified the importance of breaking the link between a person's current psychological state and the act of self-harm as a key point of intervention in reducing self-harm. Relevant skills such as shifting focus, substituting physical actions, and managing provocations could be taught under the competency areas identified by the Collaborative for Academic, Social, and Emotional Learning (CASEL) framework: self-awareness, self-management, and responsible decision making [84–86]. A second example may be to consider Schacter and colleagues' ways of enhancing episodic memory, a life-oriented thought pattern that has been studied in suicidal individuals, which describes the ability to imagine personal events in both the past and future [87]. In an

increasingly turbulent world, it is difficult to imagine a better tomorrow, let alone plan for it, especially for the young. For this reason, it is critical that USB-SEL programs help youth incorporate enhancements to episodic memory by providing brief training in recollecting details of past experiences and bridging them to creative thinking and problem-solving for the future. These skills are the foundational elements to instill hope and imagine a more livable future.

6. Discussion and Conclusions

Our perspective makes a case for shared pathways to suicidality across disparate youth groups, drawing on traditional suicide paradigms. The scope of our paper is limited to the United States, with some studies drawing on research from mainly Westernized countries. In the future, it may be illuminating to explore parallel policy developments and their outcomes for minoritized youth groups in other countries, within the context of their unique sociocultural–political settings. We also acknowledge the limitation posed by this paper's lack of a first-person lived experience perspective in the form of a case or vignette that could highlight the influence that the American sociopolitical landscape has had on suicidal behavior.

We acknowledge that our perspective is informed by our strong belief in the importance of sociopolitical structures and policies that promote the freedoms of individuals with minoritized identities, including DEI efforts. Our use of the term "post-DEI" is based on our observations of the recent sociopolitical shifts of the current Trump administration toward dismantling numerous DEI policies. While exploring alternative views is outside the scope of our perspective piece, we recognize many may hold different beliefs regarding DEI policies, including views that "merit, excellence, and intelligence" (MEI) should be prioritized in hiring and admission decisions, DEI efforts violate Constitutional protections, and DEI policies could generate backlash [88–90].

Current sociopolitical shifts have drastically destabilized what was once foundational support for vulnerable groups of youth, sowing fear and uncertainty. These recent shifts have further disintegrated social bonds and structures, promoting an increasingly atomized society. We have sought to highlight how lost meaningful connections to self, others, and society carve a shared pathway towards suicidality across very disparate youth groups; groups who are considered outliers, whether perceived by themselves or others, are particularly vulnerable. The intersubjective nature of our shared lives as humans allows us to see and verbalize what would be an unlivable life for any of us. As mental health professionals, we must lean into advocacy to build livable conditions of life within our sociocultural context and equip youth with the skills to understand and articulate their internal and external experiences, build relationships, seek support, and navigate an ever-changing and precarious landscape.

Author Contributions: The topic of this article was jointly created by M.Y.L., C.M. and K.N. The authors produced the original research and content of the article, met regularly to discuss the development, and made numerous revisions. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: No new data were created or analyzed in this study.

Conflicts of Interest: The authors declare that there are no financial or other conflicts of interest.

References

1. World Health Organization. Suicide [Internet]. 2025. Available online: https://www.who.int/news-room/fact-sheets/detail/suicide (accessed on 23 August 2025).
2. Hink, A.B.; Killings, X.; Bhatt, A.; Ridings, L.E.; Andrews, A.L. Adolescent Suicide—Understanding Unique Risks and Opportunities for Trauma Centers to Recognize, Intervene, and Prevent a Leading Cause of Death. *Curr. Trauma Rep.* **2022**, *8*, 41–53. [CrossRef]
3. Verlenden, J.V. Mental Health and Suicide Risk Among High School Students and Protective Factors—Youth Risk Behavior Survey, United States, 2023. *MMWR Suppl.* **2024**, *73*, 79–86. Available online: https://www.cdc.gov/mmwr/volumes/73/su/su7304a9.htm (accessed on 18 August 2025). [CrossRef] [PubMed]
4. Cornman, E. Youth Suicide Is on the Rise: Yale Aims to Save Lives [Internet]. 2024. Available online: https://medicine.yale.edu/news-article/youth-suicide-is-on-the-rise-yale-aims-to-save-lives/ (accessed on 5 October 2025).
5. Centers for Disease Control and Prevention. *Youth Risk Behavior Survey Data Summary & Trends Report: 2013–2023*; US Department of Health and Human Services: Washington, DC, USA, 2024.
6. Rubin, R. How Dismantling DEI Efforts Could Make Clinical Trials Less Representative. *JAMA* **2025**, *333*, 1566–1569. [CrossRef] [PubMed]
7. Dawson, L.; Kates, J. Overview of President Trump's Executive Actions Impacting LGBTQ+ Health [Internet]. KFF. 2025. Available online: https://www.kff.org/other-health/overview-of-president-trumps-executive-actions-impacting-lgbtq-health/ (accessed on 24 August 2025).
8. The White House [Internet]. Executive Orders Archives. 2025. Available online: https://www.whitehouse.gov/presidential-actions/executive-orders/ (accessed on 24 August 2025).
9. Lamont, M.; Park, B.Y.; Ayala-Hurtado, E. Trump's electoral speeches and his appeal to the American white working class. *Br. J. Sociol.* **2017**, *68* (Suppl. S1), S153–S180. [CrossRef] [PubMed]
10. Armaly, M.T.; Enders, A.M. 'Why Me?' The Role of Perceived Victimhood in American Politics. *Political Behav.* **2022**, *44*, 1583–1609. [CrossRef] [PubMed]
11. Shahtahmasebi, S. Examining the Claim that 80–90% of Suicide Cases Had Depression. *Front. Public Health* **2013**, *1*, 62. [CrossRef] [PubMed]
12. Van Hooff, A.J.L. Ancient euthanasia: 'good death' and the doctor in the graeco-Roman world. *Soc. Sci. Med.* **2004**, *58*, 975–985. [CrossRef] [PubMed]
13. Durkheim, É.; Simpson, G. *Suicide: A Study in Sociology*; Routledge Classics: London, UK, 2002; Volume 1951, 427p.
14. Van Hooff, A.J.L. (Ed.) *From Autothanasia to Suicide: Self-Killing in Classical Antiquity*; Routledge: London, UK; New York, NY, USA, 1990; 306p.
15. Pickering, W.S.F.; Walford, G. (Eds.) *Durkheim's Suicide: A Century of Research and Debate*; Routledge: London, UK; New York, NY, USA, 2000; 224p.
16. Alvarez, A. *The Savage God: A Study of Suicide*; W. W. Norton & Company: New York, NY, USA, 1990; 322p.
17. Joiner, T. *Why People Die by Suicide*; Harvard University Press: Cambridge, UK, 2009; 288p.
18. Hjelmeland, H.; Knizek, B.L. Suicide and mental disorders: A discourse of politics, power, and vested interests. *Death Stud.* **2017**, *41*, 481–492. [CrossRef] [PubMed]
19. Franklin, J.C.; Ribeiro, J.D.; Fox, K.R.; Bentley, K.H.; Kleiman, E.M.; Huang, X.; Musacchio, K.M.; Jaroszewski, A.C.; Chang, B.P.; Nock, M.K. Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychol. Bull.* **2017**, *143*, 187–232. [CrossRef]
20. Cover, R. Subjective Connectivity: Rethinking Loneliness, Isolation and Belonging in Discourses of Minority Youth Suicide. Social Epistemology [Internet]. 2020. Available online: https://www.tandfonline.com/doi/abs/10.1080/02691728.2020.1725922 (accessed on 10 August 2025).
21. Butler, J.; Worms, F. The Livable and the Unlivable [Internet]. 2024. Available online: https://academic.oup.com/fordham-scholarship-online/book/55465 (accessed on 10 August 2025).
22. Cubbage, J.; Adams, L. *Still Ringing the Alarm: An Enduring Call to Action for Black Youth Suicide Prevention*; Johns Hopkins Center for Gun Violence Solutions and Johns Hopkins Bloomberg School of Public Health, Department of Mental Health: Baltimore, MD, USA, 2023.
23. Joseph, V.A.; Martínez-Alés, G.; Olfson, M.; Shaman, J.; Gould, M.S.; Gimbrone, C.; Keyes, K.M. Trends in Suicide among Black Women in the US, 1999–2020. *Am. J. Psychiatry* **2023**, *180*, 914–917. [CrossRef] [PubMed]
24. Das, A.; Huo, S.; Bustos, B.; Masoumirad, M.; Bruckner, T.A.; Stolte, A. Racialized economic segregation and Black youth suicide in the US. *Am. J. Epidemiol.* **2025**, kwae476. [CrossRef] [PubMed]
25. SAMHSA Black Youth Suicide Prevention Initiative [Internet]. 2024. Available online: https://www.samhsa.gov/mental-health/suicidal-behavior/prevention-initiatives/black-youth-suicid (accessed on 24 August 2025).

26. Young, E. Frequent Social Media Use and Experiences with Bullying Victimization, Persistent Feelings of Sadness or Hopelessness, and Suicide Risk Among High School Students—Youth Risk Behavior Survey, United States, 2023. *MMWR Suppl.* **2024**, *73*, 79–86. Available online: https://www.cdc.gov/mmwr/volumes/73/su/su7304a3.htm (accessed on 10 August 2025). [CrossRef]
27. McKinnon, I.I. Experiences of Racism in School and Associations with Mental Health, Suicide Risk, and Substance Use Among High School Students—Youth Risk Behavior Survey, United States, 2023. *MMWR Suppl.* **2024**, *73*, 79–86. Available online: https://www.cdc.gov/mmwr/volumes/73/su/su7304a4.htm (accessed on 10 August 2025). [CrossRef]
28. Hua, L.L.; Lee, J.; Rahmandar, M.H.; Sigel, E.J. Committee on adolescence; council on injury; violence; and poison prevention Suicide and Suicide Riskin Adolescents. *Pediatrics* **2024**, *153*, e2023064800. [CrossRef] [PubMed]
29. Na, P.J.; Shin, J.; Kwak, H.R.; Lee, J.; Jester, D.J.; Bandara, P.; Kim, J.Y.; Moutier, C.Y.; Pietrzak, R.H.; Oquendo, M.A.; et al. Social Determinants of Health and Suicide-Related Outcomes. Available online: https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2828935 (accessed on 17 August 2025).
30. Madubata, I.; Spivey, L.A.; Alvarez, G.M.; Neblett, E.W.; Prinstein, M.J. Forms of Racial/Ethnic Discrimination and Suicidal Ideation: A Prospective Examination of African-American and Latinx Youth. *J. Clin. Child Adolesc. Psychol.* **2019**, *51*, 23–31. [CrossRef]
31. Oshin, L.A.; Boyd, S.I.; Jorgensen, S.L.; Kleiman, E.M.; Hamilton, J.L. Exposure to Racism on Social Media and Acute Suicide Risk in Adolescents of Color: Results From an Intensive Monitoring Study. *J. Am. Acad. Child Adolesc. Psychiatry* **2024**, *63*, 757–760. [CrossRef]
32. Tynes, B.M.; Maxie-Moreman, A.; Hoang, T.M.H.; Willis, H.A.; English, D. Online Racial Discrimination, Suicidal Ideation, and Traumatic Stress in Black Adolescents. 2024. Available online: https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2813624 (accessed on 14 August 2025).
33. Chatterjee, R. Teen Suicide Is on the Decline, New Federal Data Shows. 2025. Available online: https://www.npr.org/sections/shots-health-news/2025/08/04/nx-s1-5490050/nsduh-depression-suicide-federal-statistics-teens (accessed on 14 August 2025).
34. Lambert, R.F.; Discepolo, K.E.; Elani, H.W. Chilling Effects on Immigrants' Health Insurance Coverage After the 2016 Presidential Election. *J. Immigr. Minor. Health* **2016**, *24*, 819–826. [CrossRef] [PubMed]
35. Diallo, A. Columbia Undergraduate Law Review. The Chilling Effect: Trump's Legal Challenge on Free Speech and Journalistic Independence. 2025. Available online: https://www.culawreview.org/current-events-2/the-chilling-effect-trumps-legal-challenge-on-free-speech-and-journalistic-independence (accessed on 5 October 2025).
36. De Trinidad Young, M.E.; Tafolla, S.; Saadi, A.; Sudhinaraset, M.; Chen, L.; Pourat, N. Beyond "chilling effects": Latinx and Asian immigrants' experiences with enforcement and barriers to health care. *Med. Care* **2023**, *61*, 306–313. [CrossRef]
37. Hartocollis, A.; Bender, M.C.; Blinder, A. Trump Offered Universities an Invitation for a Deal. Some See a Trap. *The New York Times*, 2 October 2025. Available online: https://www.nytimes.com/2025/10/02/us/trump-universities-compact-funding.html?unlocked_article_code=1.tE8.2Fv_.y-RU_XsgEp4G&smid=url-share (accessed on 5 October 2025).
38. Meyer, I.H. Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychol. Bull.* **2003**, *129*, 674–697. [CrossRef] [PubMed]
39. Perez-Brumer, A.; Hatzenbuehler, M.L.; Oldenburg, C.E.; Bockting, W. Individual- and Structural-Level Risk Factors for Suicide Attempts among Transgender Adults. *Behav. Med.* **2015**, *41*, 164–171. [CrossRef]
40. Hatzenbuehler, M.L.; Pachankis, J.E. Stigma and Minority Stress as Social Determinants of Health Among Lesbian, Gay, Bisexual, and Transgender Youth: Research Evidence and Clinical Implications. *Pediatr. Clin. N. Am.* **2016**, *63*, 985–997. [CrossRef]
41. Jadva, V.; Guasp, A.; Bradlow, J.H.; Bower-Brown, S.; Foley, S. Predictors of self-harm and suicide in LGBT youth: The role of gender, socio-economic status, bullying and school experience. *J. Public Health* **2023**, *45*, 102–108. [CrossRef] [PubMed]
42. The Trevor Project: 2024 National Survey on LGBTQ+ Youth Mental Health 2024. U.S. National Survey on the Mental Health of LGBTQ+ Young People. 2024. Available online: https://www.thetrevorproject.org/ (accessed on 10 August 2025).
43. State of California. Following Trump Cut to LGBTQ Youth Suicide Hotline, California Steps Up to Fill the Gap [Internet]. 2025. Available online: https://www.gov.ca.gov/2025/07/16/following-trump-cut-to-lgbtq-youth-suicide-hotline-california-steps-up-to-fill-the-gap/ (accessed on 24 August 2025).
44. Shim, R.S. How Anti-DEI Policies Adversely Affect Mental Health. *JAMA Health Forum.* **2025**, *6*, e252163. [CrossRef] [PubMed]
45. McVittie, C.; Hepworth, J.; Goodall, K. Masculinities and Health. In *The Psychology of Gender and Health*; Elsevier: Amsterdam, The Netherlands, 2017; pp. 119–141. Available online: https://linkinghub.elsevier.com/retrieve/pii/B9780128038642000043 (accessed on 17 August 2025).
46. Addis, M.E.; Mahalik, J.R. Men, masculinity, and the contexts of help seeking. *Am. Psychol.* **2003**, *58*, 5–14. Available online: https://pubmed.ncbi.nlm.nih.gov/12674814/ (accessed on 17 August 2025). [CrossRef]
47. Courtenay, W.H. *Dying to Be Men: Psychosocial, Environmental, and Biobehavioral Directions in Promoting the Health of Men and Boys*; Routledge Series on Counseling and Psychotherapy with Boys and Men; v. 10; Routledge: New York, NY, USA, 2011; pp. xxiv+502.

48. CDC Suicide Prevention. Suicide Data and Statistics. 2025. Available online: https://www.cdc.gov/suicide/facts/data.html (accessed on 10 August 2025).
49. Cibis, A.; Mergl, R.; Bramesfeld, A.; Althaus, D.; Niklewski, G.; Schmidtke, A.; Hegerl, U. Preference of lethal methods is not the only cause for higher suicide rates in males. *J. Affect. Disord.* **2012**, *136*, 9–16. [CrossRef] [PubMed]
50. Krueger, A.B. Where Have All the Workers Gone? An Inquiry into the Decline of the U.S. Labor Force Participation Rate. *Brook. Pap. Econ. Act.* **2017**, *2017*, 1–87. [CrossRef] [PubMed]
51. Hughes, C.L.; Liu, B.; Qin, P. Socioeconomic, demographic, and occupational risk factors for suicide amongst males: A systematic review and meta-analysis. *J. Affect. Disord.* **2025**, *391*, 119986. [CrossRef]
52. Phillips, J.A.; Hempstead, K. Differences in U.S. Suicide Rates by Educational Attainment, 2000–2014. *Am. J. Prev. Med.* **2017**, *53*, e123–e130. [CrossRef] [PubMed]
53. Cunningham, R.; Milner, A.; Gibb, S.; Rijnberg, V.; Disney, G.; Kavanagh, A.M. Gendered experiences of unemployment, suicide and self-harm: A population-level record linkage study. *Psychol. Med.* **2022**, *52*, 4067–4075. [CrossRef]
54. Mathieu, S.; Treloar, A.; Hawgood, J.; Ross, V.; Kõlves, K. The Role of Unemployment, Financial Hardship, and Economic Recession on Suicidal Behaviors and Interventions to Mitigate Their Impact: A Review. *Front. Public Health* **2022**, *10*, 907052. [CrossRef]
55. Ernst, M.; Klein, E.M.; Beutel, M.E.; Brähler, E. Gender-specific associations of loneliness and suicidal ideation in a representative population sample: Young, lonely men are particularly at risk. *J. Affect. Disord.* **2021**, *294*, 63–70. [CrossRef] [PubMed]
56. Shaw, R.J.; Cullen, B.; Graham, N.; Lyall, D.M.; Mackay, D.; Okolie, C.; Pearsall, R.; Ward, J.; John, A.; Smith, D.J. Living alone, loneliness and lack of emotional support as predictors of suicide and self-harm: A nine-year follow up of the UK Biobank cohort. *J. Affect. Disord.* **2021**, *279*, 316–323. [CrossRef] [PubMed]
57. AACAP Screen Time and Children [Internet]. 2025. Available online: https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Children-And-Watching-TV-054.aspx (accessed on 24 August 2025).
58. Campelo, N.; Oppetit, A.; Neau, F.; Cohen, D.; Bronsard, G. Who are the European youths willing to engage in radicalisation? A multidisciplinary review of their psychological and social profiles. *Eur. Psychiatr.* **2018**, *52*, 1–14. [CrossRef] [PubMed]
59. Tastenhoye, C.A.; Dupré, J.; Ross, N.E.; Bodnar, T.V.; Friedman, S.H. Incels: An Introduction for Mental Health Clinicians. *J. Psychiatr. Pract.* **2023**, *29*, 384–389. [CrossRef]
60. Costello, W.; Rolon, V.; Thomas, A.G.; Schmitt, D.P. The Mating Psychology of Incels (Involuntary Celibates): Misfortunes, Misperceptions, and Misrepresentations. *J. Sex Res.* **2023**, *61*, 989–1000. [CrossRef]
61. O'Malley, R.L.; Holt, K.; Holt, T.J. An Exploration of the Involuntary Celibate (Incel) Subculture Online. *J. Interpers. Violence* **2020**, *37*, NP4981–NP5008. Available online: https://journals.sagepub.com/doi/10.1177/0886260520959625?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed (accessed on 14 August 2025). [CrossRef]
62. Brooks, R.C.; Russo-Batterham, D.; Blake, K.R. Incel Activity on Social Media Linked to Local Mating Ecology. 2022. Available online: https://pubmed-ncbi-nlm-nih-gov.ucsf.idm.oclc.org/35015599/ (accessed on 14 August 2025).
63. Preston, K.; Halpin, M.; Maguire, F. The Black Pill: New Technology and the Male Supremacy of Involuntarily Celibate Men. *Men. Masculinities* **2021**, *24*, 823–841. [CrossRef]
64. Sparks, B.; Zidenberg, A.M.; Olver, M.E. Involuntary Celibacy: A Review of Incel Ideology and Experiences with Dating, Rejection, and Associated Mental Health and Emotional Sequelae. *Curr. Psychiatry Rep.* **2022**, *24*, 731–740. [CrossRef]
65. Moskalenko, S.; González, J.F.G.; Kates, N.; Morton, J. Incel ideology, radicalization and mental health: A survey study. *J. Intell. Confl. Warf.* **2022**, *4*, 1–29. [CrossRef]
66. Sparks, B.; Zidenberg, A.M.; Olver, M.E. An Exploratory Study of Incels' Dating App Experiences, Mental Health, and Relational Well-Being. *J. Sex. Res.* **2024**, *61*, 1001–1012. [CrossRef]
67. Daly, S.E.; Laskovtsov, A. "Goodbye, My Friendcels": An Analysis of Incel Suicide Posts [Internet]. 2021. Available online: https://www.crimrxiv.com/pub/8jfu5zbb (accessed on 4 July 2025).
68. Dunlop, B.J.; Coleman, S.E.; Hartley, S.; Carter, L.; Taylor, P.J. Self-injury in young bisexual people: A microlongitudinal investigation (SIBL) of thwarted belongingness and self-esteem on non-suicidal self-injury. *Suicide Life-Threat. Behav.* **2022**, *52*, 317–328. [CrossRef] [PubMed]
69. Taylor, P.J.; Dhingra, K.; Dickson, J.M.; McDermott, E. Psychological Correlates of Self-Harm within Gay, Lesbian and Bisexual UK University Students. *Arch. Suicide Res.* **2020**, *24* (Suppl. S1), 41–56. [CrossRef]
70. Case, A.; Deaton, A. Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century. *Proc. Natl. Acad. Sci. USA* **2015**, *112*, 15078–15083. [CrossRef]
71. Hansen, H.; Netherland, J.; Herzberg, D. *Whiteout: How Racial Capitalism Changed the Color of Opioids in America*, 1st ed.; University of California Press: Oakland, CA, USA, 2023; Available online: https://www.jstor.org/stable/j.ctv33f0zpn (accessed on 24 August 2025).
72. Muennig, P.A.; Reynolds, M.; Fink, D.S.; Zafari, Z.; Geronimus, A.T. America's Declining Well-Being, Health, and Life Expectancy: Not Just a White Problem. *Am. J. Public Health* **2018**, *108*, 1626–1631. [CrossRef]

73. Shim, R.S.; Compton, M.T. Addressing the Social Determinants of Mental Health: If Not Now, When? If Not Us, Who? *Psychiatr. Serv.* **2018**, *69*, 844–846. [CrossRef]
74. English, D.; Boone, C.A.; Carter, J.A.; Talan, A.J.; Busby, D.R.; Moody, R.L.; Cunningham, D.J.; Bowleg, L.; Rendina, H.J. Intersecting Structural Oppression and Suicidality Among Black Sexual Minority Male Adolescents and Emerging Adults. *J. Res. Adolesc.* **2022**, *32*, 226–243. [CrossRef]
75. Truszczynski, M.; Truszczynski, N.; Estevez, R.I.; Elliott, A.E. Does Policy Matter? The Impact of State and City Anti-Discrimination Policy on the Discrimination Experiences of Trans and Nonbinary People. *Sex. Res. Soc. Policy* **2022**, *19*, 1786–1794. [CrossRef]
76. McDowell, A.; Raifman, J.; Progovac, A.M.; Rose, S. Association of Nondiscrimination Policies With Mental Health Among Gender Minority Individuals. *JAMA Psychiatry* **2020**, *77*, 952–958. [CrossRef]
77. Pettit, B.; Gutierrez, C. Mass Incarceration and Racial Inequality. *Am. J. Econ. Sociol.* **2018**, *77*, 1153–1182. [CrossRef] [PubMed]
78. Timmons-Mitchell, J.; Bender, M.B.; Kishna, M.A.; Mitchell, C.C. An independent effectiveness trial of multisystemic therapy with juvenile justice youth. *J. Clin. Child Adolesc. Psychol.* **2006**, *35*, 227–236. [CrossRef] [PubMed]
79. John, D.; Catherine, T. (Eds.) *National Mental Health Association (NMHA) Mental Health Treatment for Youth in the Juvenile Justice System: A Compendium of Promising Practices*; MacArthur Foundation: Chicago, IL, USA, 2004.
80. Underwood, L.A.; Washington, A. Mental Illness and Juvenile Offenders. *Int. J. Environ. Res. Public Health* **2016**, *13*, 228. [CrossRef]
81. Governor of California. Governor Newsom Issues Executive Order to Support Young Men and Boys, Address Suicide Rates [Internet]. 2025. Available online: https://www.gov.ca.gov/2025/07/30/governor-newsom-issues-executive-order-to-support-young-men-and-boys-address-suicide-rates/ (accessed on 17 August 2025).
82. Fricker, M. *Epistemic Injustice: Power and the Ethics of Knowing [Internet]*; Oxford University Press: Oxford, UK, 2007. [CrossRef]
83. Fitzpatrick, S.J. Epistemic Justice and the Struggle for Critical Suicide Literacy. *Soc. Epistemol.* **2020**, *34*, 555–565. [CrossRef]
84. Cipriano, C.; Strambler, M.J.; Naples, L.H.; Ha, C.; Kirk, M.; Wood, M.; Sehgal, K.; Zieher, A.K.; Eveleigh, A.; McCarthy, M.; et al. The state of evidence for social and emotional learning: A contemporary meta-analysis of universal school-based SEL interventions. *Child. Dev.* **2023**, *94*, 1181–1204. [CrossRef]
85. Brennan, C.A.; Crosby, H.; Sass, C.; Farley, K.L.; Bryant, L.D.; Rodriquez-Lopez, R.; Romeu, D.; Mitchell, E.; House, A.O.; Guthrie, E. What helps people to reduce or stop self-harm? A systematic review and meta-synthesis of first-hand accounts. *J. Public Health* **2023**, *45*, 154–161. [CrossRef]
86. Lawson, G.M.; McKenzie, M.E.; Becker, K.D.; Selby, L.; Hoover, S.A. The Core Components of Evidence-Based Social Emotional Learning Programs. *Prev. Sci.* **2019**, *20*, 457–467. [CrossRef] [PubMed]
87. Schacter, D.L.; Madore, K.P. Remembering the past and imagining the future: Identifying and enhancing the contribution of episodic memory. *Mem. Stud.* **2016**, *9*, 245–255. [CrossRef] [PubMed]
88. Fryer, R. The Economics of DEI and Merit. *Wall Str. J.* 2025. Available online: https://www.wsj.com/opinion/the-economics-of-dei-and-merit-hiring-productivity-1fc094d2 (accessed on 5 October 2025).
89. Ficht, L.S.; Levashina, J. Should DEI statements be included in faculty selection? Exploring legal, diversity, and validity issues. *Int. J. Sel. Assess.* **2023**, *31*, 212–224. [CrossRef]
90. Minkin, R. Views of DEI Have Become Slightly More Negative Among U.S. Workers [Internet]. Pew Research Center. 2024. Available online: https://www.pewresearch.org/short-reads/2024/11/19/views-of-dei-have-become-slightly-more-negative-among-us-workers/ (accessed on 5 October 2025).

healthcare

MDPI

Article

Mental Health Professionals' Views on the Influence of Media on Self-Harm in Young People: A Critical Discourse Analysis

Tharushi Denipitiya [1,*], Annette Schlösser [2] and Jo Bell [3]

[1] Rotherham Doncaster and South Humber NHS Foundation Trust, South Yorkshire DN4 8QN, UK
[2] Clinical Psychology, University of Hull, Hull HU6 7RX, UK; a.schlosser@hull.ac.uk
[3] Psychology and Social Work, University of Hull, Hull HU6 7RX, UK; j.bell@hull.ac.uk
* Correspondence: tharushi.denipitiya@nhs.net

Abstract

Background: Self-harm in young people is influenced by multiple factors, with media playing a significant role. While research has examined its harmful and protective effects, little attention has been paid to how healthcare professionals interpret and respond to media's role in shaping young people's experiences of self-harm. To our knowledge, no research has examined adolescent mental health professionals' perspectives and, crucially, how these are constructed and understood. The study aimed to examine the following: (1) how mental health practitioners construct and use discourses to interpret the role of media in young people's self-harm; and (2) how these discourses shape clinical understanding and practice. **Methods:** This qualitative study employed semi-structured interviews with ten clinicians from child and adolescent mental health services across England working with young people who self-harm. Data were analysed using critical discourse analysis to uncover how broader societal and institutional narratives shape clinicians' perspectives. **Results:** Two dominant discourses were identified: "Media as Disruptor" and "The Hidden World of Youth". These discourses framed media as both a risk factor and a potential intervention tool, positioning media as a powerful yet morally ambiguous force in young people's lives. Clinicians largely framed media's influence as negative but acknowledged its capacity for education and intervention. **Conclusions:** This research offers new insights into how media-related self-harm risks and benefits are framed and managed in mental health care settings. The study underscores the need for systemic changes in clinical practice, enhanced training, updated guidelines and a shift towards broader sociocultural perspectives in understanding self-harm and suicidal behaviour.

Keywords: healthcare professionals' views; self-harm; suicide; media; young people; critical discourse analysis

1. Introduction

The National Institute of Care Excellence (NICE) [1] defines self-harm as an act of self-injury or poisoning that is intentional, regardless of the assumed intention or motivation, as an expression of emotional distress. Current NICE guidelines [1] also consider suicide attempts with little or no suicidal intent as self-harm when used to communicate distress or alleviate internal tension.

Despite the NICE guideline's [1] definition of self-harm being widely used in clinical practice in the UK, the research literature highlights an overlap between self-harm and suicidal behaviours, and distinguishing between them brings challenges [2]. Self-harm

can be defined as injuring or poisoning oneself, regardless of intent [3] or without suicidal intent [4]. Suicidal behaviour can be defined as a behaviour to end one's life with suicidal intent [5]. For the purposes of this article, the terms self-harm and suicide will be used interchangeably to refer to deliberate self-injurious behaviour, regardless of suicidal intent.

Over the past two decades, self-harm rates among young people in the UK have risen significantly. In the early 2000s, the issue gained prominence with reports like Truth Hurts [6], reporting that 6.7% of young people aged 11–25 had self-harmed between 2004 and 2006. By 2014, public and professional awareness of self-harm had increased. National surveys showed rising rates of self-harm among young people, compared to earlier studies [7,8]. By 2018/19, 24% of 17-year-olds reported self-harming in the past year, with 7% stating they had self-harmed with suicidal intent during their lifetime [9]. Moreover, from 2012 to 2021, hospital admission rates for self-harm among 10–24-year-olds rose significantly from 400 per 100,000 to a peak of 550 per 100,000 [10]. These trends highlight the prevalence of self-harm and the urgent need for support for children and young people who self-harm (YPSH) in the UK.

Self-harm in young people is influenced by a complex interplay of psychological, social and environmental factors [9,11]. Research suggests that adverse childhood experiences (ACEs) can have a lasting impact, shaping individuals' coping mechanisms and increasing their vulnerability to psychological distress well into adulthood [12]. In addition to early-life adversities, more immediate stressors—such as feelings of isolation, interpersonal conflicts, academic or occupational pressures and exposure to self-harm—have been identified as key triggers for self-injurious behaviours among young adults [13]. These findings highlight the multifaceted nature of self-harm, reflecting both deep-seated emotional struggles and the broader challenges of emerging adulthood.

Furthermore, self-harm serves a range of functions, from expressing distress to attempting emotional regulation or exerting a sense of control in moments of uncertainty [14–16]. These motivations underscore the profound interplay between internal turmoil and external stressors, reinforcing the need to consider both individual experiences and wider societal influences when examining self-harming behaviours.

1.1. The Role of Media in Self-Harm and Suicide: A Growing Concern

One of the most important wider societal influences is media, which has become increasingly embedded in young people's everyday lives over recent years, shaping their perceptions, behaviours and interactions with the world. Research [17] highlights that media portrayals of self-harm and suicide—whether through news reports, fictionalised content or social media—may inadvertently amplify risks for vulnerable individuals. Studies suggest that the normalization and sensationalisation of self-harm in media contribute to heightened risk [18,19]. Research further emphasises the impact of highly publicised portrayals on suicide rates [20]. For example, the release of the television series 13 Reasons Why [21], which depicted the suicide of a young person, was associated with an increase in suicide rates among young audiences in the US.

The impact of media on suicidal behaviours has been commonly understood through two key foundational concepts: the Werther Effect [22] and the Papageno Effect [23]. The Werther Effect describes how exposure to suicidal behaviours in media can increase suicide rates by encouraging imitation; a phenomenon supported by research indicating that sensationalist portrayals can exacerbate suicidal behaviours [24,25]. Conversely, the Papageno Effect highlights the potential of responsible media reporting to prevent suicide by promoting narratives of resilience, coping strategies and recovery [23]. Together, these perspectives illustrate the dual role of media in both contributing to harmful behaviours or serving as a protective factor through constructive portrayals.

Beyond media portrayals, the nature of young people's media use itself is a growing area of concern. Bell and Westoby [26] argue that today's media landscape is far more pervasive and interactive than ever before, leading to increased exposure to self-harm-related discourse and content. This shift has heightened accessibility to unmoderated content, making the media's role in influencing self-harm behaviours more powerful and difficult to manage [27]. A striking example of this is the case of Molly Russell, a 14-year-old girl in the UK who died by an act of self-harm after prolonged exposure to distressing online content. The 2022 inquest into her death concluded that she had suffered from "the negative effects of online content" [28], marking the first time social media influence was explicitly linked to a cause of death.

However, the media's influence on self-harm is not wholly negative. Digital spaces also provide young people with avenues for support, education and community [29–31]. Online forums, mental health advocacy campaigns and personal recovery narratives have been found to offer valuable support for young people experiencing distress. While some forms of media content may glamorise or reinforce self-harm, others contribute to awareness, prevention and access to professional help.

Recent reviews of international research reflect this duality in the role of media influence on YPSH [32–36]. A systematized review [32] found that YPSH are more active on social media than their peers, often using these platforms for connection and support, while also being at risk of harmful exposure and psychological distress. Similarly, a narrative review [33] highlighted both risk and protective factors across 38 studies, noting social media's role in exacerbating self-harm for vulnerable young people but also its potential for suicide prevention.

Despite the well-documented dual influences of media on self-harm among young people, there remains a pressing need for professionals working with this population to deepen their understanding of media's impact and to integrate this knowledge into clinical practice [29,33,37]. Recent scholarship has shifted focus in this direction. For example, a large-scale meta-analysis [34] reinforced the importance of focusing on the *nature and quality* of online engagement. A practitioner-oriented systematic review [34] underscored the need for open, developmentally appropriate clinical conversations to mitigate harm while respecting young people's autonomy. Consistent with these findings, a scoping review [36] called for a more nuanced, balanced and context-sensitive approach to research and practice.

While prior research has examined the influence of media content on YPSH, there is a marked absence of research exploring how healthcare professionals themselves make sense of this influence in clinical settings. Critically, clinicians' perspectives not only shape the quality of care and support provided to young people [38,39], but also influence how risk is assessed, managed and responded to within services. Despite the centrality of clinician perspectives in shaping care pathways, no existing studies have specifically explored how adolescent mental health professionals conceptualise and respond to media's role in self-harm, or how these understandings are discursively constructed within broader institutional and sociocultural contexts.

This study directly addresses this gap. To our knowledge, it is the first study to examine adolescent mental health professionals' perspectives on the influence of media on YPSH through a social constructionist lens. In doing so, it offers a novel contribution to the field by shifting focus from media content and adolescent behaviours to the interpretive frameworks clinicians use. Given the increasing rates of YPSH [10], the rising number of YPSH engaging with mental health services [40] and the increasing awareness of media's role as a risk factor, this research is particularly timely. Insights from this study could

inform interventions, risk assessment frameworks and professional training to better address media-related risks.

1.2. Exploring Media and Self-Harm Through a Social Constructionist Lens

A social constructionist approach provides a valuable framework for examining how the influence of media on YPSH is understood and constructed in clinical discourse. Social constructionism posits that knowledge and meaning are shaped by social interactions, language and cultural contexts [41]. This perspective challenges fixed or essentialist understandings of self-harm, instead emphasising how discourse, power dynamics and historical context shape how self-harm is framed and responded to in clinical practice.

Four key aspects of social constructionism—language, cultural and historical specificity, discourse and power dynamics—are particularly relevant to this study. Language is central to how self-harm is understood, as it determines how experiences are represented and interpreted [42]. Cultural and historical specificity highlights how perceptions of self-harm evolve over time and differ across societies. Discursive and disciplinary power shape dominant narratives, influencing whether self-harm is framed as an individual pathology, a social phenomenon or a consequence of systemic issues [29]. Finally, power dynamics play a critical role in clinical practice, as professionals hold authority in defining risk, vulnerability and appropriate interventions [43].

This study contributes to the existing literature by offering new insights into the influence of media on YPSH through a social constructionist lens. It aims to examine the following: (1) how mental health practitioners construct and use discourses to interpret the role of media in YPSH; and (2) how these discourses shape clinical understanding and practice. By analysing the discourses used by mental health professionals, the study advances current knowledge in three key ways. First, it shifts analytical focus from the impact of media on young people to the ways in which mental health professionals construct meaning around media's role in self-harm, a perspective that has been largely overlooked in the existing literature. Second, by applying a social constructionist lens, it challenges dominant, individualised understandings of self-harm [44] and foregrounds the sociocultural and institutional discourses that shape clinical practice. Third, the study provides practical insights into how these discourses influence clinical responses, potentially informing more reflective and context-sensitive approaches to care.

2. Materials and Methods

This is a qualitative study using semi-structured interviews. Participants were 10 English-speaking clinicians from child and adolescent mental health services (CAMHSs) across England (3 males; 7 females). All had at least one year's experience of working with YPSH within a CAMHS setting. They were recruited through purposive and snowball sampling [45].

The study did not collect data on participants' age, race/ethnicity, education level and sexual orientation as the focus was on discourse rather than individual characteristics [46]. As individual characteristics were not under examination, in the interest of participant anonymity, it was deemed best not to collect the information [47].

Interviews were conducted via Microsoft Teams and recorded with clinicians' consent. Interviews lasted approximately one hour, and clinicians were debriefed afterwards. The interviews were designed to provide rich qualitative data, offering insights into how clinicians construct and interpret media's influence on YPSH. Questions explored clinicians' roles and experiences of working with YPSH, their workplace practices and their perspectives on how societal and media narratives shape attitudes towards self-harm. Key areas of discussion included the following: young people's engagement with media

(news, television, film, social media and the internet) and its perceived impact on self-harm; how media is discussed within clinical settings and the extent to which it is considered in assessments and interventions; clinicians' perceptions of media portrayals of self-harm and how these representations influence public and professional attitudes; the influence of clinicians' own perspectives on their approach to care; direct experiences with media-related self-harm cases and reflections on how media exposure may contribute to young people's self-harming behaviours.

2.1. Ethics

The University of Hull's Faculty of Health Sciences Research Ethics Committee and the Health Research Authority provided ethical approval for the study.

2.2. Data Analysis

Data from the interviews were analysed using critical discourse analysis (CDA) [48]. CDA aligns with the social constructionist approach of the study, allowing for examination of the data through the perspective that an individual's reality is shaped through discourse with both internal reflections and external interactions [41]. Using CDA allowed the researchers to examine constructions of meaning surrounding the influence of media on self-harm [49].

Interviews were transcribed verbatim and analysed according to the seven-step CDA process [48]. The professional roles of the interviewees were noted. Transcripts were then coded, and overarching discourses were identified. Similarities across transcripts and any positionalities the interviewees suggested were noted. Internal relations in the transcripts were highlighted by analysing any patterns, words or linguistic devices depicting social context, interviewees' positionalities and power relations [48]. Finally, major discourses and the internal and external relations were interpreted. During this process, the researcher noted their reflections on how their perspectives may have influenced the analysis, questions, gaps and any insights [48].

2.3. Reflexivity

This study is grounded in relativist ontology and social constructionist epistemology, viewing knowledge as shaped by context and social interaction [41,50]. These informed the use of qualitative methods and CDA. At the time, the lead researcher who undertook data collection was a trainee clinical psychologist. Their clinical experience with YPSH and CAMHS professionals informed the research focus and helped build rapport. Ongoing reflexivity was maintained through journaling and regular supervision to manage potential bias [51]. The co-authors (a clinical psychologist and an academic) supported the lead researcher through regular, reflexive supervision and contributed to data analysis, interpretation and writing through relativist and social constructionist lenses.

We acknowledge that our backgrounds—as clinical and academic professionals with varying degrees of proximity to the subject matter, from different generations and different cultural backgrounds, with different family/professional roles and responsibilities—inevitably shaped the research process. We consider our diverse perspectives a resource for generating rich, multi-layered interpretations, provided we remain vigilant to the risks of over-identification or blind spots. Our commitment to reflexivity, transparency and collaborative analysis was central to ensuring the rigor of our qualitative inquiry [52].

3. Results

Data analysis revealed two dominant discourses: "Media as a Disruptor" and "The Hidden World of Youth". These discourses cover the impact of media on YPSH and reflect

clinicians' perceptions as well as highlighting how language (including metaphors and constructions) positions YPSH within the context of the influence of media and self-harm.

3.1. Media as a Disruptor

The discourse of media as a disruptor appeared across all interviews. This discourse emphasises how media is seen as a powerful system influencing young people's behaviours and perceptions relating to self-harm. The analysis revealed several sub-discourses within the main discourse: "Ease and Facilitation of Access", "Multifaceted Nature of Media", "Inaccuracy of Portrayals" and "Pathologising Behaviours".

3.1.1. Ease of Facilitation of Access

In this sub-discourse, media is portrayed as a facilitator of dangerous knowledge, with all clinicians expressing concern over the unrestricted access young people have to harmful content relating to self-harm. For example,

> *"…..it allows young people access to information that they shouldn't really have. It's not monitored. You know, some parents don't feel like they have the control to put boundaries in place . . .and they have access to information. They have forums where they can find out how to self-harm. They get tips, and chat rooms. So I think it has a real influence on young people."* (clinician 2, CAMHS crisis consultant, female)

The clinician used lexical choices such as "shouldn't really have", "not monitored" and "real influence" to indicate the danger of easy access to media. The repetition of the verb "access" highlights how easy it is to access harmful information relating to self-harm, whilst the phrases "find out how to self-harm" and "get tips" indicate a direct link between media and the facilitation of self-harm behaviours. The use of modal verbs like "should" and "can" implies a prescriptive stance on what is appropriate for young people, which positions the media as overstepping boundaries regarding easy access to inappropriate material relating to self-harm.

Clinician 5 further reinforces this perception:

> *"So I feel like outside influences do impact their relationship with media and how often they access things that. . .might lead to them. . . self-harm in all might sort of start off that spiral that ends in self-harm."* (healthcare assistant in a CAMHS inpatient unit, female)

The phrase "outside influences" is a metonym for media, indicating external factors, such as friends, beyond parental or clinical control. The clinician's use of the verb "spiral" metaphorically suggests a downward, uncontrollable trajectory that can be initiated by exposure to media. The hesitations and pauses ("…") reflect the clinician's struggle to articulate the complex process of media influence and highlights the deceptive nature of the exposure to media.

3.1.2. Multifaceted Nature of Media

Clinicians also acknowledged the multifaceted role of media, framing its potential for both harm and benefit:

> *"The the young person who was hiding or holding the medication. . ..found out that if I take 1000 milligrams of so and so. . .. I'll kill myself. I can die and that's where. . .the information came from so I don't know. Yeah, that's quite alarming. At the same time, we've got young people on inpatient that belongs to a suicide pact. . . meeting total strangers. . .on social media and getting ideas about self-harming and. . .hurt themselves . . .but at the same time, there's one or two young people who meet people online, and they've been advising or please talk to your doctor. . .ring your phone telling your mum*

about what is happening, so it's kind of. . .it's a two-way things. . ..it's it's sometimes positive. And I've had examples of being positive at the same time. I've had examples of where it is quite negative and alarming." (clinician 3, specialty doctor in a CAMHS inpatient unit, male)

The clinician above juxtaposed harmful and protective aspects of media. The repetition of "at the same time" aims to balance the multifaceted nature of media influence. The clinician's narrative shifts from alarming scenarios ("hiding or holding the medication" and "suicide pact") to more positive interactions ("advising" and "please talk to your doctor"). The lexical choice "alarming" contrasts with "positive", implying the ambivalent impact of media.

This is echoed by clinician 6:

"And I guess, you know, there's lots of. . .access. . .to many different and. . .at many different kind of sites and apps and. . .I don't even know how. . .how we keep track of them all, to be honest. So. . .I think. . .it I'm defensive about it. . .I think it can be really good when it's used well and it can be the devil's playground. . .a lot of the time. I then also think that there is an element of, actually, is there too much?" (core CAMHS practitioner, female)

The use of the metaphor "devil's playground" describes the potential dangers of media, suggesting it is chaotic with a dubious reputation. The phrase "when it's used well" acknowledges the positive potential of media, while the rhetorical question "Is there too much?" implies the overwhelming nature of the ever changing and growing landscape of media.

3.1.3. Inaccuracy of Portrayals

This sub-discourse reveals how clinicians challenge dominant media representations of self-harm, exposing underlying ideological constructions that can misinform and stigmatise:

"You know, it's not, it's not some some planned out you know like as you say romanticised event it's it's not anything like how it's portrayed in that programme but for the young person you know they think that that's what it's like because that's their only experience of being shown. . ..whole thing, so definitely damaging." (clinician 5, healthcare assistant in a CAMHS inpatient unit, female)

Clinician 5's use of repeated negation ("not some planned out" and "not anything like") functions as a discursive strategy to dismantle media narratives that romanticise self-harm. This repetition constructs a binary opposition between media portrayals and the clinician's experiential knowledge, reinforcing the idea that popular representations are not only inaccurate but potentially harmful. The term "romanticised" operates as a loaded evaluative term, suggesting that media narratives may aestheticise or trivialise self-harm, transforming it into a consumable spectacle rather than a serious mental health issue. In doing so, the clinician articulated concern over media's influence on young people, framing them as susceptible to these distorted narratives due to limited alternative representations ("that's their only experience of being shown").

The phrase "definitely damaging" further consolidates a discourse of harm, whereby the media is positioned as a powerful actor capable of shaping perceptions and, by implication, behaviours. This construction reinforces a broader ideological critique of media as a space where complex psychological realities are oversimplified and commodified.

"Negative. . .Yeah, there's still. . .Yeah, it's interesting. . ..there's this real idea, or I guess the perception that somebody might have when . . . something like that is. . ..put out there in the way that it is with a bias that that young person is damaged. Broken. There's something you know, must be something, really. . ..difficult that they're going, you know.

And I'm not saying there isn't, but I guess the the kind of portrayal of that is always really, you know, really negative." (clinician 7, clinical lead in a CAMHS crisis team, male)

Clinician 7's fragmented syntax, marked by hesitations ("yeah. . .there's this real idea, or I guess the perception. . .") reflects the struggle in articulating an issue that is both ideologically charged and personally emotive. The clinician's lexical choices—particularly "damaged" and "broken"—reveal the internalisation and critique of dominant discourses that frame YPSH through a pathologising lens. These metaphors signal a powerful ideological framing in which self-harm is equated with deficiency or malfunction, perpetuated through biased media narratives.

The repetition of the evaluative phrase "really negative" at the end of the extract intensifies the critique and highlights the pervasiveness of stigmatising portrayals. This functions not only as a critique of media bias but also as a call for a more nuanced and respectful representation of young people's mental health in public discourse.

3.1.4. Pathologising Behaviours

This sub-discourse also criticises media and how it can unnecessarily pathologise common behaviours in young people.

"I feel. . ..that there are more influencers getting involved with regards to mental health, which therefore means that mental health seems to be a very hot topic . . .and it makes people who may be struggling. . .but it's a struggle that is in keeping with the situation, so it's a normal emotional feeling, start questioning whether whether they're suffering from mental health problems." (clinician 2, CAMHS crisis consultant, female)

The use of the phrase "hot topic" suggests mental health difficulties are being sensationalised and unnecessarily pathologised in the media. The contrast between the phrases "mental health problems" and "normal emotional feeling" suggests that the media can blur the lines between young people's typical behaviours and mental health difficulties which may lead to needless self-diagnosis.

This is also reinforced by clinician 9:

"And I suppose, yeah, trying to sort of. . ..get parents to be open to the idea that emotional instability in adolescence is really quite normal. . ..but yeah, but because somebody had said it on the telly, that was, yeah, the kind of the battle that we had that month."

(CAMHS crisis assessment practitioner, female)

The term "emotional instability" is used as a nominalisation that abstracts and generalises the concept, while "quite normal" sets out to normalise young people's behaviours. The clinician's reference to "somebody had said it on the telly" implies the authoritative power of the voices of the media, which can override clinical advice and complicate therapeutic efforts.

3.2. Hidden World of Youth

This discourse focuses on how young people's use and engagement with media (and associated difficulties) is often hidden from parents, carers and clinicians. It also reveals clinicians' suggestions for strategies to address media influence and highlights the need for improvements in the approach to caring for YPSH. Three sub-discourses were developed: "Asking About Media in Assessments", "Risk Assessments" and "Importance of Further Education".

3.2.1. Asking About Media in Assessments

All clinicians described the need to integrate discussions about media consumption into initial assessments with YPSH:

> *"But yeah, I think it's something that often it it will speak about it if they bring it up. I would say it wouldn't be something that I would proactively discuss. . ..No, but I feel like it probably should have to change. I don't feel like. . . I probably should be better at that. . ...I think maybe just asking those questions more and just saying to people, because often it's it's offered by them. Really what what they want to share about their. . .media awareness and how much they pay attention to things. . ., so we don't do assessments like that in our team typically. So that because of the nature of the way that we work. . .unless it was an identified problem, I wouldn't naturally bring it up unless they did with me."* (clinician 8, mental health nurse in a CAMHS intensive community support team, female)

The clinician's hesitation and self-reflection ("I would say it wouldn't be something" and "I probably should be") indicate an awareness of the gap in current practice and a recognition of the need for improvements and change to the care for YPSH. The phrase "proactively discuss" indicates that this approach is different from the previous reactive approach, suggesting a shift towards a more deliberate inclusion of questions related to media consumption in assessments with YPSH.

3.2.2. Risk Assessments

This discourse on risk assessments reveals concerns about the length and rigidity, which can hinder rapport, therapeutic relationship building and engagement with YPSH as demonstrated by clinicians 1 and 4:

> *"It is easy to have a questionnaire about risk. . . And you, you you can ask those questions. . . reading it from a clipboard or you can engage in a conversation. . . and know the know the bits that you need to hit to write a really good risk assessment, but without it feeling like the young person's just being interrogated* (clinician 1, CAMHS clinical lead, male)

Clinician 1 contrasted the impersonal nature of a "questionnaire" with the relational approach of a "conversation". The repetition of "you" and the juxtaposition of "clipboard" versus "conversation" highlight the clinician's preference for a more interactive and less intimidating method of assessment.

> *"A risk assessment which at the moment in our services are very, very lengthy documents. So I think it's almost gone back to that filling a full session on risk and I don't think that's necessarily been useful. . ..I would say. . ..yeah, I almost wish that in this setting it we. . .. we steer away from focusing solely on risk, but ensuring that the young person feels that their individual needs are still being met despite the risk, if that makes sense."* (clinician 4, CAMHS practitioner, female)

The clinician's use of the phrase "very, very lengthy" and "filling a full session" implies how burdensome current risk assessments can be. The wish for a shift away from "focusing solely on risk" suggests a need for a more balanced approach that can address both the risk and the internal world of what matters for YPSH:

> *"Yeah, and . . .. It can also, I guess, reinforce dynamics of infantilization and victimisation, and it can prevent clinicians from. . ..seeing and sharing and celebrating the strengths that the child has and the you know the rest of their internal world, which might be rich and fulfilling and. . ..you know, we can miss that and we can reinforce. . .the problem itself, inadvertently through through that sense of threat that we have and. . .yeah, I guess the proverbial kind of tail that wags the dog rather than the dog that wags the tail. . ..kind of. . ..that can be what happens, can't it with these processes, that should be just the tip of the iceberg of what we're doing and should be there to serve what we're doing, but instead*

can become. . .the beginning and the end and the the middle of it all. Yeah, it's a risk."
(clinician 10, clinical psychologist in a CAMHS children in care team, female)

The clinician elaborated on the negative dynamics that can arise from a rigid focus on risk. They used complex metaphors ("tail that wags the dog") and idiomatic expressions ("tip of the iceberg") to illustrate the unintended consequences of a risk-focused approach. The phrase "reinforce dynamics of infantilisation and victimisation" critiques how risk-focused assessments can diminish the power and strengths of young people. This in turn can affect the rapport building, therapeutic relationship and the care of the young person.

3.2.3. Importance of Further Education

Clinicians highlighted the need for ongoing education and training to understand and explore the impact of media on YPSH:

"I think it is definitely shown me how little I know about this area. And I think as you quite rightly said. . .having an understanding of what it is that you know of the world, the online worlds that young people are inhabiting. . .and the exposure, you know what it what they are exposed to is so crucial for actually being able to engage with them and for them to feel understood and. . .potentially disclose what's going on so that it's been really helpful on that on that front. And it's made. It made me want to go and do my own research. Really. And, you know, I don't know where that would begin because I'm sure it would lead to all of the things we've talked about that rabbit holes that. Yeah, but I think I think you're right. Some training around this. . ..sounds very appropriate, yeah"
(clinician 10, clinical psychologist in a CAMHS children in care team, female)

Here, the clinician's narrative constructs a position of professional inadequacy and uncertainty in the face of rapidly evolving media landscapes, as evidenced by the admission: "it is definitely shown me how little I know about this area." This serves to highlight a perceived knowledge-power gap between clinicians and YPSH. The phrase "having an understanding. . .of the online worlds that young people are inhabiting" reflects the discursive separation of clinicians from youth digital cultures, implicitly constructing these online environments as distinct, unfamiliar and potentially threatening domains. The clinician drew a boundary between professional expertise and the lived experiences of YPSH, situating the latter as an area in need of increased institutional knowledge through "training".

Repetition of the term "exposure" works to foreground media as an omnipresent and potentially harmful force, constructing a narrative in which young people are framed as passive recipients of media content, thereby requiring protection or interpretation by informed adults. This aligns with a paternalistic discourse that reinforces adult authority and positions youth as vulnerable.

The metaphor of "rabbit holes" is particularly revealing, invoking imagery of depth, confusion and danger. It contributes to a discourse of media as a chaotic and unknowable terrain, potentially undermining clinicians' authority and simultaneously justifying the call for structured training and the discourse of professional uncertainty that legitimises further institutional investment in media-related education.

4. Discussion

Our findings align with and extend insights from the existing research that highlights the complex and ambivalent role of social media in YPSH [32–34]. These studies underscore the dual nature of media—a view echoed by clinicians in our study. Our work builds on this literature by offering a critical discursive lens, showing how UK mental health professionals construct media as simultaneously harmful and potentially supportive and

how these constructions shape their clinical reasoning and interactions with YPSH. Our findings also resonate with practitioner-focused research [35,36], which has advocated for a more nuanced, context-sensitive understanding of media use and both risk and resilience. Importantly, our study brings added attention to how clinicians' views may inadvertently underplay young people's capacity for media literacy, resilience and self-regulation—factors that are increasingly recognised as protective in the literature. These parallels reinforce the relevance of our discursive approach in exploring how clinicians grapple with this complexity in practice.

Our analysis sheds light on two prominent discourses: "Media as a Disruptor" and "The Hidden World of Youth", which encapsulate the complex relationship between media consumption and YPSH. These discourses reveal how language and underlying ideologies construct and shape the understanding of YPSH and their interactions with suicide- and self-harm-related media. The discourse of "Media as Disruptor" positions media as a powerful, almost omnipresent force that significantly influences young people's perceptions and behaviours. By framing media as a "disruptor", the language reflects a duality: media is both a source of risk (facilitating access to harmful content) and a tool for potential mitigation (educational and supportive content). This dual framing reflects broader societal anxieties about media's influence and its moral ambiguity. The emphasis on media's transformative influence constructs it as an agent of power, often overshadowing young people's agency. This framing risks portraying them as passive consumers of media, subject to its influence, rather than active participants navigating and resisting harmful discourses.

The sub-discourses of "Ease and Facilitation of Access" and "Inaccuracy of Portrayals" highlight how media shapes the normalisation and glamorisation of self-harm through content on media platforms, such as forums and chat rooms, where self-harm techniques are sometimes openly discussed and even encouraged. From a CDA perspective, these constructions reflect societal preoccupations with control and moral regulation. The language emphasises how repeated exposure to certain narratives or imagery desensitises viewers, making self-harm seem more acceptable or inevitable. This draws on a broader cultural discourse of media as a homogenising force, blurring the boundaries between deviant and normative behaviours [53]. However, these discourses often fail to fully account for young people's awareness of these dynamics and their ability to disengage from harmful content.

The discourse of "Pathologising Behaviours" highlights how media frames self-harm in ways that reduce it to a clinical issue or spectacle. This could inadvertently marginalise the sociocultural and emotional complexities of self-harm, simplifying the phenomenon to fit media's demand for sensationalised or digestible content.

Patalay and Fitzsimmons [9] and McManus et al. [11] identified the widespread use of media platforms as sources of both information and encouragement for self-harming behaviours among young people. These findings lend authority to the claims about the risks of media exposure to suicide-related content, while the inclusion of clinicians' perspectives situates the discussion within a professional context. This interplay legitimises the argument while potentially marginalising alternative narratives, such as the empowering aspects of young people's media use. While some media content sensationalises or glamorises self-harm, documentaries and educational content have the potential to raise awareness and connect individuals with support services [54,55]. This polarity highlights the importance of critically evaluating representations of self-harm in media while recognising that young people are not passive consumers but active participants who interpret, engage with and navigate media in complex ways.

The discourse of "Hidden World of Youth" constructs a narrative of young people's lives as inaccessible, veiled by the complexities of digital interactions: it highlights the often private, inaccessible or misunderstood aspects of YPSH lives, particularly in the

context of their interactions with digital media. This "hidden world" encompasses online spaces, behaviours and social dynamics that YPSH engage in, which can be difficult for parents, carers and health practitioners to fully grasp due to the unique ways young people navigate and use social media. The framing of online spaces as "rabbit holes" or "devil's playgrounds" employs metaphorical language that evokes danger, mystery and moral panic. By emphasising the "hidden" nature of young people's worlds, the discourse implicitly critiques adult institutions—such as parents, carers and clinical systems—for failing to keep pace with youth culture [56]. This reveals a broader ideological tension between generations and their differing relationships with digital media [57]. Reframing this "hidden world" as a space of both vulnerability and empowerment opens possibilities for clinicians to better support young people's resilience, recognising that not all online experiences are inherently pathological.

4.1. Clinical Implications

The findings highlight power dynamics, ideological underpinnings and systemic limitations inherent in current clinical approaches. The discourse of "media as a disruptor" reframes media not only as an external influence but as a critical factor shaping the lived experiences of YPSH. Media has significantly altered the environment in which young people are growing up, shaping their cognitive, social and emotional development in ways that are distinct from previous generations. Integrating discussions about media consumption into clinical assessments becomes a means of unearthing the "hidden world" of young people. This approach reflects the necessity of challenging reductionist clinical practices that prioritise overt risk indicators over nuanced understandings of complex social and emotional contexts. It also creates opportunities for clinicians to recognise and build upon young people's media literacy and capacity for critical engagement, rather than assuming a position of vulnerability alone.

By exploring young people's media interactions, clinicians can dismantle the taken-for-granted assumptions about media as a neutral or wholly negative force. Instead, media is positioned as a site of complex negotiation, where triggers, social identities and coping mechanisms intersect. This perspective invites a more collaborative approach that foregrounds young people's agency, adaptability and reflexivity in their lives. Such inquiry disrupts conventional power dynamics in clinical settings, allowing young people to co-construct their narratives rather than having their experiences pathologised or oversimplified.

The discourse surrounding risk assessments underscores the professional's role in perpetuating institutionalised practices that prioritise efficiency over relational depth. These assessments often rely on procedural checklists, reflecting a broader institutional discourse of control and standardisation. The study challenges this framework, arguing for a shift towards risk assessments that foster dialogical engagement with YPSH. This shift calls for practices that privilege narrative depth and emotional resonance, disrupting the clinician−client hierarchy and enabling the co-production of meaning. Such practices also create space to explore how young people manage and interpret their own media environments, empowering them to reflect on their agency and strategies for navigating online risk. Clinicians should proactively inquire about young people's media use, paying particular attention to the types of content they are exposed to, the frequency with which they engage and how it may influence their self-harm behaviours. Integration of these questions can help clinicians gain valuable insights for more targeted and holistic care plans.

The absence of media-specific guidance in current NICE assessment and management guidelines reflects a gap in institutional discourses around self-harm and media. Importantly, although current NICE guidelines [1] provide an extensive framework for working

with YPSH, guidance regarding the impact and role of media on self-harm is currently absent. While acknowledging the significance of social media and internet use amongst YPSH, the guidelines do not provide recommendations for interventions, safety planning, harm minimisation and clinician training regarding media use. By failing to explicitly address the role of suicide- and self-harm-related media, these guidelines inadvertently reinforce a discourse of omission, where media's pervasive impact on young people is minimised or ignored. Updating NICE guidelines to include media-specific strategies for interventions and safety planning—such as personalised media safety plans, safe spaces and online resources for YPSH—would signify a discursive shift towards acknowledging the sociotechnical realities of self-harm. This shift would not only validate young people's experiences but also challenge the medical and risk-oriented frameworks that currently dominate clinical practices. It would also recognise young people's agency, whose insights and choices can inform more balanced, ethical and empowering responses to online content.

The discourse of "the hidden world of youth" emphasises systemic challenges within clinical practice and underscores the necessity of equipping clinicians with the skills to engage meaningfully with the evolving media landscape. Our findings advocate that NICE guidance should also include recommendations regarding training for clinicians–training which interrogates both the content and the context of media use, enabling clinicians to critically evaluate and respond to the cultural and ideological forces at play. Such training should also equip professionals to recognise and support young people's strengths—such as their media literacy, peer support networks and self-help practices—as potential resources in care planning. This would support clinicians to engage in open conversations that recognise young people's autonomy in navigating media and enable clinicians to work collaboratively with both caregivers and young people to develop strategies for safer media engagement. This cooperative approach promotes shared responsibility, ensuring that media use is managed in a way that prioritises well-being while respecting young people's perspectives and experiences.

4.2. Limitations of the Study

Several limitations should be acknowledged, which may affect the transferability of the findings. The study relied on self-reported data obtained through a small number of semi-structured interviews, introducing the possibility of self-selection and social desirability biases [58]. Nine of the ten participants were recruited from a single region in England, resulting in a geographically limited sample; a larger and more diverse sample could yield a broader range of perspectives. The design of the study also precludes causal inferences regarding the relationship between media exposure and self-harm behaviours. Longitudinal quantitative research examining changes in media use and self-harm over time would offer a stronger basis for identifying causal pathways.

Finally, the study focused only on the perspectives of clinicians, neglecting the voices of YPSH and their parents or carers. Future research should seek to include these perspectives and investigate how YPSH respond to the clinician discourses identified here. Future research should also explore the efficacy of training programs tailored to address the challenges clinicians face in understanding "The Hidden World of Youth", incorporating the perspectives of YPSH and evaluative research on training interventions. This would generate more specific recommendations to enhance clinical training for mental health professionals.

5. Conclusions

To our knowledge, this is the first study to employ a CDA approach to examine healthcare professionals' perspectives on the influence of media on self-harming behaviours in young people and how these are constructed and understood. Through an analysis and interpretation of the discourses of "Media as a Disruptor" and "The Hidden World of Youth", the findings highlighted how these discourses are constructed through language and reflect broader societal concerns, positioning media as a powerful yet morally ambiguous force in young people's lives.

Clinicians predominantly framed media's influence on YPSH as negative, emphasizing risks such as desensitisation, glamorisation, and the normalisation of self-harm. This framing, however, risks oversimplifying media's role and neglecting young people's agency in navigating their digital environments. The findings underscore the need for systemic changes in clinical practice, including the integration of media-specific enquiries into assessments, enhanced training to critically evaluate the influence of media and the development of updated guidelines that promote personalised media safety strategies.

Author Contributions: T.D., conceptualization, methodology, formal analysis, investigation, data curation, writing—original draft preparation, writing—review and editing and project administration. A.S., conceptualisation, methodology, formal analysis, investigation, writing—original draft preparation, writing—review and editing and supervision. J.B., formal analysis, investigation, writing—original draft preparation, writing—review and editing and supervision. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of University of Hull (protocol code: FHS 22-23.68 and 16 June 2023) and the NHS Health Research Authority (protocol code: 23/HRA/3304 and 18 August 2023).

Informed Consent Statement: Informed consent was obtained from all participants involved in the study. Written informed consent has been obtained from the participant(s) to publish this paper.

Data Availability Statement: The data presented in this study are not available on request from the corresponding author due to ethical and confidentiality reasons.

Acknowledgments: We are grateful for the initial assistance and guidance of Paul Walton at the conceptual stages of this study. We also thank all the clinicians who took part in this study for their time and expertise.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

NICE	National Institute of Care Excellence
YPSH	young people who self-harm
ACE	adverse childhood experience
CAMHS	child and adolescent mental health services
CDA	critical discourse analysis

References

1. National Institute for Health and Care Excellence. National Institute for Health and Care Self-Harm: Assessment, Management and Preventing Recurrence. 2022. Available online: https://www.nice.org.uk/guidance/ng225 (accessed on 4 April 2024).
2. James, K.; Stewart, D. Blurred Boundaries—A qualitative study of how acts of Self-Harm and attempted suicide are defined by mental health practitioners. *Crisis* **2017**, *39*, 247–254. [CrossRef]

3. Rahman, F.; Webb, R.T.; Wittkowski, A. Risk factors for self-harm repetition in adolescents: A systematic review. *Clin. Psychol. Rev.* **2021**, *88*, 102048. [CrossRef]
4. Baetens, I.; Decruy, C.; Vatandoost, S.; Vanderhaegen, B.; Kiekens, G. School-Based Prevention Targeting Non-Suicidal Self-injury: A pilot study. *Front. Psychiatry* **2020**, *11*, 437. [CrossRef]
5. O'Donnell, S.; Egan, T.; Clarke, N.; Richardson, N. Prevalence and associated risk factors for suicidal ideation, non-suicidal self-injury and suicide attempt among male construction workers in Ireland. *BMC Public Health* **2024**, *24*, 1263. [CrossRef]
6. Brophy, M.; Mental Health Foundation. *Truth Hurts: Report of the National Inquiry Into Self-Harm Among Young People: Fact or Fiction?* Mental Health Foundation: London, UK, 2006. Available online: https://www.mentalhealth.org.uk/sites/default/files/2022-09/truth-hurts-report.pdf (accessed on 2 April 2024).
7. Hawton, K.; Saunders, K.E.; O'Connor, R.C. Self-harm and suicide in adolescents. *Lancet* **2012**, *379*, 2373–2382. [CrossRef]
8. Brooks, F.; Magnusson, J.; Klemera, E.; Chester, K.; Spencer, N.; Smeeton, N. *HBSC England National Report 2014*; University of Hertfordshire: Hatfield, UK, 2014. Available online: https://core.ac.uk/reader/287581560 (accessed on 4 July 2025).
9. Patalay, P.; Fitzsimons, E. *Mental Ill-Health at Age 17 in the UK: Prevalence of and Inequalities in Psychological Distress, Self-Harm and Attempted Suicide*; Centre for Longitudinal Studies: London, UK, 2020. Available online: https://cls.ucl.ac.uk/wp-content/uploads/2020/11/Mental-ill-health-at-age-17-%E2%80%93-CLS-briefing-paper-%E2%80%93-website.pdf (accessed on 10 April 2024).
10. Newlove-Delgado, T.; Marcheselli, F.; Williams, T.; Mandalia, D.; Davis, J.; McManus, S.; Savic, M.; Treloar, W.; Ford, T. *Mental Health of Children and Young People in England, 2023—Wave 4 Follow up to the 2017 Survey*; NHS Digital: London, UK, 2023. Available online: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up (accessed on 8 April 2024).
11. McManus, S.; Gunnell, D.; Cooper, C.; Bebbington, P.E.; Howard, L.M.; Brugha, T.; Jenkins, R.; Hassiotis, A.; Weich, S.; Appleby, L. Prevalence of non-suicidal self-harm and service contact in England, 2000–2014: Repeated cross-sectional surveys of the general population. *Lancet Psychiatry* **2019**, *6*, 573–581. [CrossRef]
12. Long, M.; Manktelow, R.; Tracey, A. We are all in this together: Working towards a holistic understanding of self-harm. *J. Psychiatr. Ment. Health Nurs.* **2012**, *20*, 105–113. [CrossRef]
13. Hetrick, S.E.; Subasinghe, A.; Anglin, K.; Hart, L.; Morgan, A.; Robinson, J. Understanding the needs of young people who engage in Self-Harm: A Qualitative investigation. *Front. Psychol.* **2020**, *10*, 2916. [CrossRef]
14. Adshead, G. Written on the body: Deliberate self-harm as communication. *Psychoanal. Psychother.* **2010**, *24*, 69–80. [CrossRef]
15. Barton-Breck, A.; Heyman, B. Accentuate the positive, eliminate the negative? The variable value dynamics of non-suicidal self-hurting. *Health Risk Soc.* **2012**, *14*, 445–464. [CrossRef]
16. Ogden, J.; Bennett, A. Self-harm as a means to manage the public and private selves: A qualitative study of help seeking by adults. *Health Psychol. Open* **2015**, *2*, 205510291560598. [CrossRef] [PubMed]
17. Hawton, K. Influences of the media on suicide. *BMJ* **2002**, *325*, 1374–1375. [CrossRef] [PubMed]
18. Arendt, F.; Scherr, S.; Romer, D. Effects of exposure to self-harm on social media: Evidence from a two-wave panel study among young adults. *New Media Soc.* **2019**, *21*, 2422–2442. [CrossRef]
19. Daine, K.; Hawton, K.; Singaravelu, V.; Stewart, A.; Simkin, S.; Montgomery, P. The Power of the Web: A systematic review of studies of the influence of the Internet on Self-Harm and Suicide in Young people. *PLoS ONE* **2013**, *8*, e77555. [CrossRef] [PubMed]
20. Bridge, J.A.; Greenhouse, J.B.; Ruch, D.; Stevens, J.; Ackerman, J.; Sheftall, A.H.; Horowitz, L.M.; Kelleher, K.J.; Campo, J.V. Association between the release of Netflix's 13 Reasons Why and Suicide Rates in the United States: An Interrupted Time Series analysis. *J. Am. Acad. Child Adolesc. Psychiatry* **2019**, *59*, 236–243. [CrossRef]
21. Yorkey, B.; Son, D. 13 Reasons Why. 2017. Available online: https://www.netflix.com/title/80117470 (accessed on 6 April 2024).
22. Phillips, D.P. The influence of suggestion on suicide: Substantive and theoretical implications of the Werther Effect. *Am. Sociol. Rev.* **1974**, *39*, 340. [CrossRef]
23. Niederkrotenthaler, T.; Voracek, M.; Herberth, A.; Till, B.; Strauss, M.; Etzersdorfer, E.; Eisenwort, B.; Sonneck, G. Role of media reports in completed and prevented suicide: Werther v. Papageno effects. *Br. J. Psychiatry* **2010**, *197*, 234–243. [CrossRef]
24. Sisask, M.; Värnik, A. Media Roles in Suicide Prevention: A Systematic review. *Int. J. Environ. Res. Public Health* **2012**, *9*, 123–138. [CrossRef]
25. Stack, S. Media coverage as a risk factor in suicide. *J. Epidemiol. Community Health* **2003**, *57*, 238–240. [CrossRef]
26. Bell, J.; Westoby, C. Suicide exposure in a polymediated age. *Front. Psychol.* **2021**, *12*, 694280. [CrossRef]
27. Competiello, S.K.; Bizer, G.Y.; Walker, D.C. The power of social media: Stigmatizing content affects perceptions of mental health care. *Soc. Media + Soc.* **2023**, *9*, 20563051231207847. [CrossRef]
28. BBC News. Molly Russell Inquest: Online Life Was "The Bleakest of Worlds". BBC News. Available online: https://www.bbc.co.uk/news/uk-england-london-62981964 (accessed on 6 April 2024).

29. Bell, J. Harmful or helpful? The role of the internet in self-harming and suicidal behaviour in young people. *Ment. Health Rev. J.* **2014**, *19*, 61–71. [CrossRef]
30. Bell, J.; Mok, K.; Gardiner, E.; Pirkis, J. Suicide-Related Internet Use Among Suicidal Young People in the UK: Characteristics of Users, Effects of Use, and Barriers to Offline Help-Seeking. *Arch. Suicide Res.* **2017**, *22*, 263–277. [CrossRef] [PubMed]
31. House, A.; Brennan, C. *Social Media and Mental Health*; Cambridge University Press: Cambridge, UK, 2023. [CrossRef]
32. Memon, A.; Sharma, S.; Mohite, S.; Jain, S. The role of online social networking on deliberate self-harm and suicidality in adolescents: A systematized review of literature. *Indian J. Psychiatry* **2018**, *60*, 384. [CrossRef]
33. Biernesser, C.; Sewall, C.J.R.; Brent, D.; Bear, T.; Mair, C.; Trauth, J. Social media use and deliberate self-harm among youth: A systematized narrative review. *Child. Youth Serv. Rev.* **2020**, *116*, 105054. [CrossRef]
34. Nesi, J.; Burke, T.A.; Bettis, A.H.; Kudinova, A.Y.; Thompson, E.C.; MacPherson, H.A.; Fox, K.A.; Lawrence, H.R.; Thomas, S.A.; Wolff, J.C.; et al. Social media use and self-injurious thoughts and behaviors: A systematic review and meta-analysis. *Clin. Psychol. Rev.* **2021**, *87*, 102038. [CrossRef]
35. Khalaf, A.M.; Alubied, A.A.; Khalaf, A.M.; Rifaey, A.A. The Impact of social media on the mental health of adolescents and young Adults: A systematic review. *Cureus* **2023**, *15*, e42990. [CrossRef]
36. Harris, R.; Hills, L.; McKee, T.; Victor-Uadiale, I. *Social Media—Its Use and Impact on Mental Health and Wellbeing Among Young People. Findings from the Literature, with a Focus on Self-Harm and Suicidality*; NHS Greater Glasgow & Clyde: Scotland, UK, 2024.
37. Padmanathan, P.; Biddle, L.; Carroll, R.; Derges, J.; Potokar, J.; Gunnell, D. Suicide and Self-Harm related internet use. *Crisis* **2018**, *39*, 469–478. [CrossRef]
38. Saunders, K.E.A.; Hawton, K.; Fortune, S.; Farrell, S. Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *J. Affect. Disord.* **2011**, *139*, 205–216. [CrossRef]
39. Coimbra, L.R.R.; Noakes, A. A systematic review into healthcare professionals' attitudes towards self-harm in children and young people and its impact on care provision. *J. Child Health Care* **2021**, *26*, 290–306. [CrossRef]
40. Huang, H.C.-H.; Ougrin, D. Impact of the COVID-19 pandemic on child and adolescent mental health services. *BJPsych Open* **2021**, *7*. [CrossRef] [PubMed]
41. Burr, V. *Social Constructionism*; Routledge: London, UK, 2015. [CrossRef]
42. Burr, V.; Dick, P. Social Constructionism. In *The Palgrave Handbook of Critical Social Psychology*; Palgrave Macmillan London: London, UK, 2017; Volume 1, pp. 59–80. [CrossRef]
43. Ocloo, J.; Goodrich, J.; Tanaka, H.; Birchall-Searle, J.; Dawson, D.; Farr, M. The importance of power, context and agency in improving patient experience through a patient and family centred care approach. *Health Res. Policy Syst.* **2020**, *18*, 10. [CrossRef]
44. Dempsey, R.C.; Fedorowicz, S.E.; Wood, A.M. The role of perceived social norms in non-suicidal self-injury and suicidality: A systematic scoping review. *PLoS ONE* **2023**, *18*, e0286118. [CrossRef] [PubMed]
45. Negrin, K.A.; Slaughter, S.E.; Dahlke, S.; Olson, J. Successful recruitment to Qualitative Research: A critical reflection. *Int. J. Qual. Methods* **2022**, *21*, 16094069221119576. [CrossRef]
46. Tannen, D.; Hamilton, H.E.; Schiffrin, D. (Eds.) *The Handbook of Discourse Analysis*, 2nd ed.; John Wiley & Sons: Hoboken, NJ, USA, 2015. [CrossRef]
47. Joseph, P. 'It's All Public Anyway': A Collaborative Navigation of Anonymity and Informed Consent in a Study with Identifiable Parent Carers. *Ethics Soc. Welf.* **2023**, *17*, 191–205. [CrossRef]
48. Mullet, D.R. A General Critical Discourse Analysis Framework for Educational research. *J. Adv. Acad.* **2018**, *29*, 116–142. [CrossRef]
49. White, R. Discourse analysis and social constructionism. *Nurse Res.* **2004**, *12*, 7–16. [CrossRef]
50. Baghramian, M. *Relativism: Philosophical Aspects*; Elsevier: Amsterdam, The Netherlands, 2001; pp. 13012–13018. [CrossRef]
51. Zienkowski, J. Reflexivity in the transdisciplinary field of critical discourse studies. *Palgrave Commun.* **2017**, *3*, 17007. [CrossRef]
52. Johnson, J.L.; Adkins, D.; Chauvin, S. A review of the quality Indicators of rigor in Qualitative research. *Am. J. Pharm. Educ.* **2020**, *84*, 7120. [CrossRef]
53. Sinaga, L.R.; Larasati, A. The role of mass media in the emergence of deviant behavior in society. *J. Indones. Sos. Sains* **2024**, *5*, 799–804. [CrossRef]
54. Gandhi, A.; Luyckx, K.; Goossens, L.; Maitra, S.; Claes, L. Association between Non-Suicidal Self-Injury, Parents and Peers Related Loneliness, and Attitude Towards Aloneness in Flemish Adolescents: An Empirical Note. *Psychol. Belg.* **2018**, *58*, 3–12. [CrossRef] [PubMed]
55. Diggins, E.; Kelley, R.; Cottrell, D.; House, A.; Owens, D. Age-related differences in self-harm presentations and subsequent management of adolescents and young adults at the emergency department. *J. Affect. Disord.* **2016**, *208*, 399–405. [CrossRef]

56. Berzins, K.; Baker, J.; Louch, G.; Albutt, A. A qualitative exploration of mental health service user and carer perspectives on safety issues in UK mental health services. *Health Expect.* **2020**, *23*, 549–561. [CrossRef] [PubMed]
57. Comunello, F.; Rosales, A.; Mulargia, S.; Ieracitano, F.; Belotti, F.; Fernández-Ardèvol, M. 'Youngsplaining' and moralistic judgements: Exploring ageism through the lens of digital 'media ideologies'. *Ageing Soc.* **2020**, *42*, 938–961. [CrossRef]
58. Rosenman, R.; Tennekoon, V.; Hill, L.G. Measuring bias in self-reported data. *Int. J. Behav. Healthc. Res.* **2011**, *2*, 320. [CrossRef]

healthcare

MDPI

Article

The "Supporting Adolescents with Self Harm" (SASH) Intervention Supporting Young People (And Carers) Presenting to the Emergency Department with Self-Harm: Therapeutic Assessment, Safety Planning, and Solution-Focused Brief Therapy

Rose McCabe [1,*], Sally O'Keeffe [2] and Maria Long [1]

[1] School of Health and Medical Sciences, City St. George's, University of London, London EC1R 1UW, UK
[2] Population Health Sciences Institute, Newcastle University, Newcastle upon Tyne NE1 7RU, UK; sally.o'keeffe@newcastle.ac.uk
* Correspondence: rose.mccabe@citystgeorges.ac.uk

Abstract

Background: Self-harm is a growing public health concern and the strongest predictor of suicide in young people (YP). The "Supporting Adolescents with Self-Harm" (SASH) intervention was developed with YP with lived experience and expert clinicians. It involves rapid follow-up after ED attendance and up to six intervention sessions. The intervention has three components: Therapeutic Assessment (TA) of self-harm; an enhanced safety plan (SP); and Solution-Focused Brief Therapy (SFBT). Depending on the YP's preference, carers can join sessions. Carers can also receive two individual sessions. The clinical and cost-effectiveness of SASH is being evaluated in a randomised controlled trial across nine emergency departments in three NHS Trusts in London, England. A total of 154 YP were recruited between May 2023 and March 2025 and randomised on a 1:1 ratio to SASH alongside Treatment As Usual (TAU) or TAU. A logic model describes the SASH inputs, activities, mechanisms, outcomes and longer-term impacts. The aim of this paper is to (1) illustrate how TA, SP, and SFBT were implemented in practice by presenting intervention materials and session recordings for four YP cases and one carer case and (2) explore how the case study materials/recordings reflect the intervention mechanisms in the SASH logic model. **Methods**: Each case focused on a different component of the intervention. Intervention materials (TA self-harm diagram and completed SP) and recorded SFBT sessions with four YP and one carer were analysed using a descriptive case study approach. The TA diagram and SP were extracted from medical records. Audio/video recordings of intervention sessions were identified. Recordings of intervention sessions and qualitative interviews were transcribed. Quotes from qualitative interviews with the same participants were included where relevant. **Results**: Across the four YP cases, some core themes emerged. The role of friendships for young people, particularly at school, was important in both negative and positive ways. Experiencing difficulties with friends at school led to feelings of sadness and stress, which could become overwhelming, leading to thoughts of self-harm ("I just need to hurt myself"), triggering self-harm behaviour. YP described mood changes and signs that they were becoming stressed, which improved their self-awareness and understanding of the link between their feelings and self-harm behaviour. They reflected on what kept them feeling calm and overcoming their fear of burdening others by sharing how they were feeling, as this helped them not to self-harm. They also described difficult feelings stemming from a need to please everyone or needing validation from others. Overcoming these feelings led to less social anxiety and more

confidence. This made it easier to go to school and to be more social with friends/student peers, which in turn improved their mood. **Conclusions**: These case studies demonstrate how YP improved their self-awareness and understanding of the link between feelings and self-harm behaviour and identified personal strategies for managing difficult feelings and situations. The carer case study demonstrates how sessions with carers can facilitate carers better supporting their YP's mental health. Supporting YP and carers in this way has the potential to reduce the risk of future self-harm.

Keywords: self-injurious behaviour; suicide prevention; adolescent; emergency service; crisis intervention; carers

1. Introduction

Self-harm is a growing public health concern. Self-harm is defined as any "intentional self-poisoning or injury irrespective of the apparent purpose of the act" [1]. The 2023/24 UK government figures show that in young adults (ages 16–24 years old), 31.5% reported lifetime suicide thoughts, 24.6% reported having self-harmed and 10.3% reported a lifetime suicide attempt [2]. Self-harm is the strongest risk factor for suicide in young people (YP), which is one of the leading causes of death in YP [3]. Over 50% of those under 20 who die by suicide have a history of self-harm [4]. YP who visit the emergency department (ED) with self-harm have up to a 50-fold risk of future suicide. This makes the ED a crucial opportunity for intervening as early as possible with YP presenting with self-harm.

In England, the National Institute for Health and Care Excellence (NICE) recommends a psychosocial assessment by specialist mental health practitioners in the ED for YP who present with self-harm and a 7-day follow-up [1]. Practitioners from Child and Adolescent Mental Health Services (CAMHS) crisis teams conduct psychosocial assessments to assess mental health, risks, care needs, and agree on a management plan. Follow-up within 7 days seeks to provide appropriate aftercare, including reviewing the risk and onward referrals. However, evidence from a meta-synthesis found that YP often report that ED treatment for self-harm exacerbates their distress and that EDs are unable to meet their needs [5]. Difficult experiences of ED deter future help-seeking and contribute to vicious cycles of repeat ED attendances and escalating suicidality [6]. A recent review found that the international picture is consistent with that in the UK; globally, many YP receive neither assessment in the ED nor follow-up, and only around half are referred on for further input from community mental health services [7].

While there are few psychological interventions for YP presenting to the ED with self-harm, different activities have been investigated. A novel approach to the assessment of self-harm in YP is Therapeutic Assessment (TA). It involves describing the YP's personal cycle of self-harm to help the YP understand their emotions and self-harm behaviour, along with possibilities for breaking the cycle [8]. TA is a promising approach that is therapeutic in seeking to understand the complex reasons and psychological "core pain" that drives self-harm in young people. A previous non-randomised study found that YP who received TA were more likely to engage in follow-up care after attending the ED and less likely to harm themselves [9].

Safety plans (SPs) have been investigated and found to be effective for suicide prevention in adults. However, research on safety plans with YP is limited [10]. A non-randomised study evaluating an intervention that included safety planning in a mixed sample of adolescents partially recruited from emergency departments saw reductions in suicidal ideation and behaviour at 6-month follow-up [11]. Support for YP after discharge is lacking due to

https://doi.org/10.3390/healthcare14020168

underfunding and increasing rates of CAMHS referrals [12]. As a result, many YP who have presented to the ED with self-harm may require further support and are referred to CAMHS but end up on lengthy waiting lists for treatment: YP are typically waiting over one year for CAMHS treatment in the UK [13]. The gap between demand and availability of services is an international problem, as data from North America reveal a similar picture of YP facing lengthy waits to access treatment [14]. Long wait times prolong distress and exacerbate YP's mental health difficulties [15]. A recent report found that 26% of YP attempted suicide while waiting for CAMHS treatment [16]. Deteriorating mental health also has wider impacts on school absence and poorer social and educational development.

Solution-focused brief therapy (SFBT) is a strengths-based intervention where YP are considered experts in their own lives. In other settings, SFBT is as effective as other evidence-based treatments, but progress happens in fewer sessions: This requires fewer resources, making it potentially more cost-effective (average 4–5 sessions, compared to 8 for other talking therapies) [17,18]. As it is a brief systemic approach, it has the potential to support YP and families in a mental health crisis.

To address the current gap in rapid interventions for YP in crisis, we developed the Supporting Adolescents with Self-Harm (SASH) intervention with the input of YP/carers with lived experience and mental health clinicians. The SASH intervention aims to provide rapid follow-up within 1–2 weeks after attending the ED. It includes up to six sessions over approximately 2 months with YP and parents/carers. The intervention comprises the following: (1) TA of self-harm, addressing the YP's core pain, their cycle of self-harm, and identifying how to break this cycle; (2) an enhanced SP based on the Stanley and Brown model; and (3) SFBT where the YP/carer identifies their future hopes and resources to help them move forward in their lives. Depending on the YP's preference, parents/carers are invited to join sessions with the YP. Carers can also receive two individual sessions focused on psychoeducation around self-harm and their best hopes for themselves and their child. Evidence shows that involving families and the system supporting the YP improves outcomes for YP [18].

The clinical and cost-effectiveness of the SASH intervention in addition to TAU is currently being evaluated in a randomised controlled trial in England. It is being compared to Treatment As Usual (TAU), and the primary outcome is repeat self-harm after 6 months. Full details are described in the trial protocol [19] (https://sashstudy.co.uk/, accessed on 19 December 2025). Secondary outcomes include symptoms of depression and anxiety, ED reattendance, death by suicide, school attendance, and psychological wellbeing (see [19] for all outcomes), collected at baseline and 6-month follow-up. A total of 154 YP were recruited into the trial and are currently being followed up, with follow-up data collection having recently been completed. SASH draws on existing components of self-harm interventions that have been tested in previous studies, including Therapeutic Assessment (TA), safety planning, and SFBT. The aim of this paper is to (1) illustrate how TA, safety planning, and SFBT were implemented in practice by presenting intervention materials/recordings for four YP cases and one carer case and (2) explore how the case study materials/recordings reflect the intervention mechanisms in the SASH logic model. A future publication will report on the clinical and cost-effectiveness of the SASH intervention.

2. Materials and Methods

2.1. Setting

We present intervention materials and recordings from the SASH trial. SASH is a multicentre parallel group individually randomised controlled trial (RCT). YP and carers were recruited across nine ED departments in west, north, central, and east London. The trial has been described in full elsewhere [19]. CAMHS practitioners working with YP in

https://doi.org/10.3390/healthcare14020168

crisis were trained in the SASH approach across 1.5–2 days. A manual, training videos, and handouts were provided to practitioners to support the delivery of the intervention and adherence to the approach. Practitioners were invited to weekly group supervision with senior members of the research team to discuss cases and discuss the delivery of the intervention in line with NHS Trust clinical processes and policies.

2.2. The Intervention

The intervention comprises up to six sessions with YP and their carers. The first session is delivered within approximately seven days of ED attendance. Subsequent sessions are delivered at approximately two-week intervals. Sessions are primarily delivered face-to-face, though remote delivery is possible where permitted by clinical services. Intervention delivery is designed to be flexible to maximise engagement. In response to changes in risk or worsening of presentation, clinicians can refer YP on for more support or for specialist assessment. The first session includes TA and safety planning, while follow-up sessions are SFBT sessions. To ensure consistency in intervention delivery across sites, the research team met regularly with practitioners (aiming for every two weeks), encouraged attendance at weekly supervision, and provided top-up training in specific areas (e.g., working with parents/carers). To assess intervention fidelity, two researchers independently applied a bespoke fidelity scale to a sample of practitioner intervention session notes. Bespoke logs were developed to monitor adherence to the intervention and record practitioner supervision attendance. We worked with senior leadership teams in services to support practitioner attendance at supervision alongside their clinical commitments.

2.3. Therapeutic Assessment

TA was developed by Ougrin et al. specifically for YP presenting with self-harm in crisis [8]. It is a novel approach to working with YP (and families), derived from solution-focused and systemic traditions. It involves joint production of a diagram of the self-harm cycle, with three elements: identification of core pain, maladaptive behaviours, and means to break the cycle. YP are asked to identify a previous episode of self-harm. Diagrams are constructed using the YP's language and aim to identify and understand the YP's difficulties, instil hope, and provide a foundation for therapeutic change. See Figure S1 in the Supplementary Materials for a schematic of the TA diagram.

2.4. Enhanced Safety Planning

The SP is an adapted version of the Stanley and Brown model of safety planning [20] and involves co-construction of an individualised safety plan in the YP's own words. This consists of two sections: the first section describes the YP when they are well and what they like to do, what helps them to stay well, and what might get in the way of this. The second section relates to warning signs of self-harm and means of managing thoughts of self-harm, including individual actions (distractions and changing environment), and support networks that can be drawn on (contacting trusted others and professionals). The SP can be in paper or electronic form and can be completed either by the YP, practitioner, or jointly. For enhanced safety plan template, see Figure S2.

2.5. Solution-Focused Brief Therapy

The follow-up sessions (up to five) involve SFBT. SFBT is a strengths-based intervention involving a paradigm shift from problem reduction to promoting strengths and new ways of thinking and behaving. SFBT is as effective as other evidence-based treatments but is achieved in fewer sessions (average 4–5 sessions). A systematic review and meta-analysis found that SFBT is effective for YP and adult depression, low self-esteem, family dynamics, relationship problems, and parental stress in community settings [21]. SFBT for carers has

https://doi.org/10.3390/healthcare14020168

been found to improve YP mental health [22]. SFBT's focus on the therapeutic relationship empowers YP to experience a more hopeful future through collaboratively formulating solutions and how to move forward [23–26]. For SFBT templates, see Figures S3 and S4.

2.6. Parent/Carer Involvement

According to the YP's preference and consent, parents/carers may join sessions with the YP. Parent/carer involvement can support the YP emotionally, improve their understanding of the YP's experience, and increase awareness of strategies that can be used by the YP. Parents/carers may be invited to participate in a joint SFBT session with the YP, where a shared understanding of what the YP and parent/carer may be generated. In addition to joining the sessions with their YP, parents/carers are offered 1–2 of their own individual sessions (these may involve more than one parent/carer) where clinicians take a solution-focused approach and offer psychoeducation for self-harm. We will explore the effects of parent/carer involvement systematically in statistical analyses in the randomised controlled trial.

2.7. Data Collection

2.7.1. Participants

Participants were identified from the group of YP in the SASH intervention arm (n = 78), who had either intervention session recordings available or intervention-related materials uploaded to their medical records. Parents/carers of YP in the intervention arm were selected if they had an individual or joint intervention session recording available.

2.7.2. Procedure

Participants provided informed consent for audio/video recording for intervention sessions and qualitative interviews and specified consent for the use of this data as part of consent for participating in the trial. Audio/video files were transcribed using a two-step procedure; firstly, a secure auto-transcription tool was used to capture the live interaction and was downloaded, after which auto-transcripts were manually checked and corrected for accuracy. Before recording, practitioners reaffirmed the participants' consent to be recorded. Recordings were made on secure, encrypted devices and were securely transferred to approved electronic storage. All identifying details were removed from transcripts, and participants were assigned pseudonyms.

2.7.3. Sampling

1. Intervention sessions and documents

Of the pool of young people assigned to the intervention arm (n = 78), we reviewed all available intervention session transcripts (n = 16) and intervention-related materials (TA diagrams n = 7, SPs n = 8, SFBT handouts n = 16). The intervention manual and fidelity scale were used to guide the selection of cases with acceptable fidelity to the intervention manual. Selections were made by reviewing transcripts of intervention sessions and intervention materials to identify exemplars of each of the three intervention components. We also aimed to capture variation across the type of session (YP only and parent/carer session only). All data were anonymised prior to analysis. Assessments of fidelity to the intervention will be published alongside the main trial results.

2. Qualitative interviews

Purposive sampling was used in the SASH trial to invite YP from the intervention arm and practitioners who delivered the intervention to take part in a qualitative interview as part of the process evaluation. Full transcripts were reviewed, and excerpts were identified that corresponded to that person's TA, SP, and SFBT sessions. Practitioner qualitative

https://doi.org/10.3390/healthcare14020168

transcripts were reviewed for reflections on the implementation of the intervention relating to the activities and mechanisms of change.

2.8. Data Analysis

A descriptive case study approach [27] was taken when analysing the intervention materials and recordings. Activities and mechanisms of change from the SASH logic model were used as a framework to guide the presentation of each component of the intervention.

The logic model in Figure 1 was developed based on existing evidence of how the different components of the SASH intervention are intended to influence outcomes, informed by literature review, expert input, and refined iteratively during intervention delivery. Inputs, activities, mechanisms of action, outcomes, and impact outline the theory of change underpinning the intervention. Inputs relate to resources and assets which support the intervention, for example, practitioner training and supervision; activities relate to actions or processes which are both specific to the different components of the intervention and generic across the approach; mechanisms of change relate to how and why the intervention achieves its intended outcomes; outcomes relate to the intended consequences of the intervention and impact relates to the longer term effects of the SASH intervention on key stakeholders. In the trial, we administered a measure of the quality of the therapeutic relationship post-intervention (or TAU), as we hypothesise that this outcome may mediate the effect of the intervention. Other mechanisms in the logic model will be explored in qualitative and quantitative analyses.

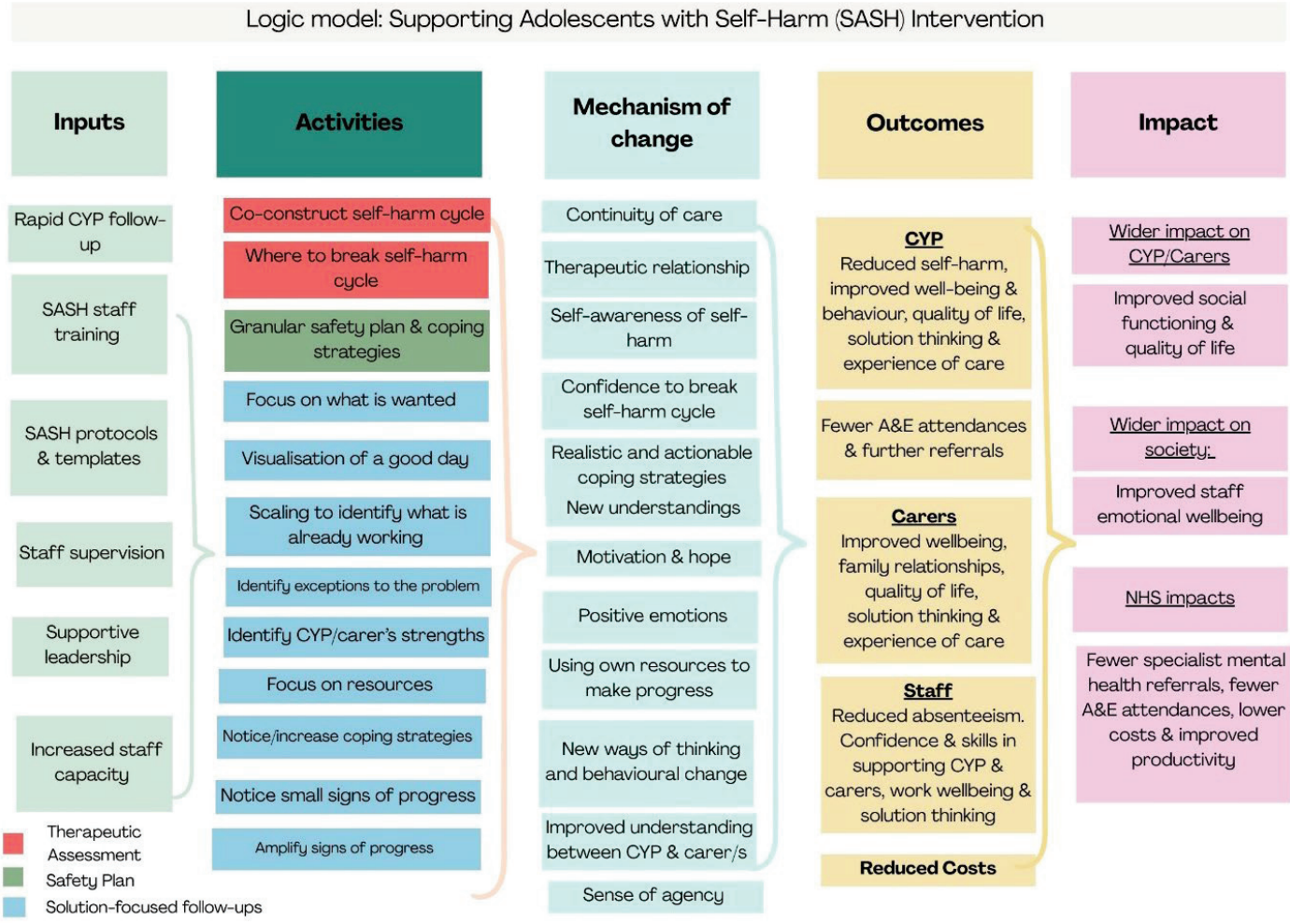

Figure 1. SASH intervention logic model.

2.9. Ethics

The SASH study was approved by the London-Riverside Research Ethics Committee (Ref: 22/LO/0400). Fully informed written consent was sought from YP, parents/carers, and practitioners. For YP under the age of 16 years, written assent was sought in addition to fully informed written parental consent. YP, carer, and practitioner consent forms included optional items for audio/video recording of sessions: When this optional consent was obtained from all parties, sessions were recorded where possible by the practitioner. Pseudonyms have been used and identifying details changed to preserve anonymity in the presentation of the case studies.

3. Results

Five case studies are presented, as shown in Table 1. The case studies include four YP who received the SASH intervention, each focusing on a different component of the intervention (TA, SP, and SFBT) and one parent/carer (mother) of a YP who received the SASH intervention.

Table 1. Participant characteristics.

Pseudonym	YP/Carer	ED Presentation	Age	Gender	Neurodiversity	Ethnicity	No. Sessions Attended
Adah	YP	Suicide attempt	13	F	N	Mixed ethnic background	5
Eliana	YP	Suicide attempt	15	F	N	Black British	5
Charlotte	YP	Suicidal ideation (and recent self-harm)	14	F	N	White British	5
Wai	YP	Suicide attempt	16	F	N	Other—Hong Kong and Indonesia	4
Michelle	Carer	N/A	53	F	N	Black British	1

3.1. Case Study 1: Therapeutic Assessment of Self-Harm with Adah

In most cases, the TA was conducted in person in the first session, within one week of ED attendance. As the SASH intervention was provided in addition to TAU, this session also typically included a reassessment of risk, mental state, and a check-in around referrals and contact with other agencies, e.g., social care, which is what would be provided in the TAU routine 7-day follow-up. The practitioner report suggests that TA took longer on average with early teens and with YP who are neurodivergent, taking longer to identify feelings and link behaviours together in a chain. Practitioners could use the "Feelings Wheel" [28] from the intervention manual to help YP identify emotions, consider relevant adaptations such as using emoji scales instead of numbers, and were advised to spend additional time building rapport with YP if needed.

Case study 1 focuses on the TA of Adah, who presented to the ED with a suicide attempt. She received five sessions in total across 3 months. During the first session, the YP and practitioner *co-constructed the self-harm cycle* (see Figure 2). The YP began by describing the events leading up to her suicide attempt and explained that she had been feeling stressed and sad (core pain) while at school due to issues in her friendship group (trigger) and felt the only way to deal with these overwhelming feelings was to take an overdose. When she took the overdose, she described experiencing a clear mind (short-term relief). She then started to reflect on what she had done, felt panic and worry, started crying, and had a panic attack. This led to disclosure about the overdose to school staff, who called an ambulance. When she reached the hospital, she felt safe because she was in the ED but described feeling worried about herself and what she had done, which led to feelings of confusion and sadness and disbelief at her actions (long-term negative consequences). She identified that she would choose to *break the self-harm cycle* by noticing when she is feeling stressed or has mixed emotions, for example, after friendship conflict, and identified a

https://doi.org/10.3390/healthcare14020168

range of things as part of safety planning that she can do instead of self-harming, building a sense of *confidence in alternative means of coping*.

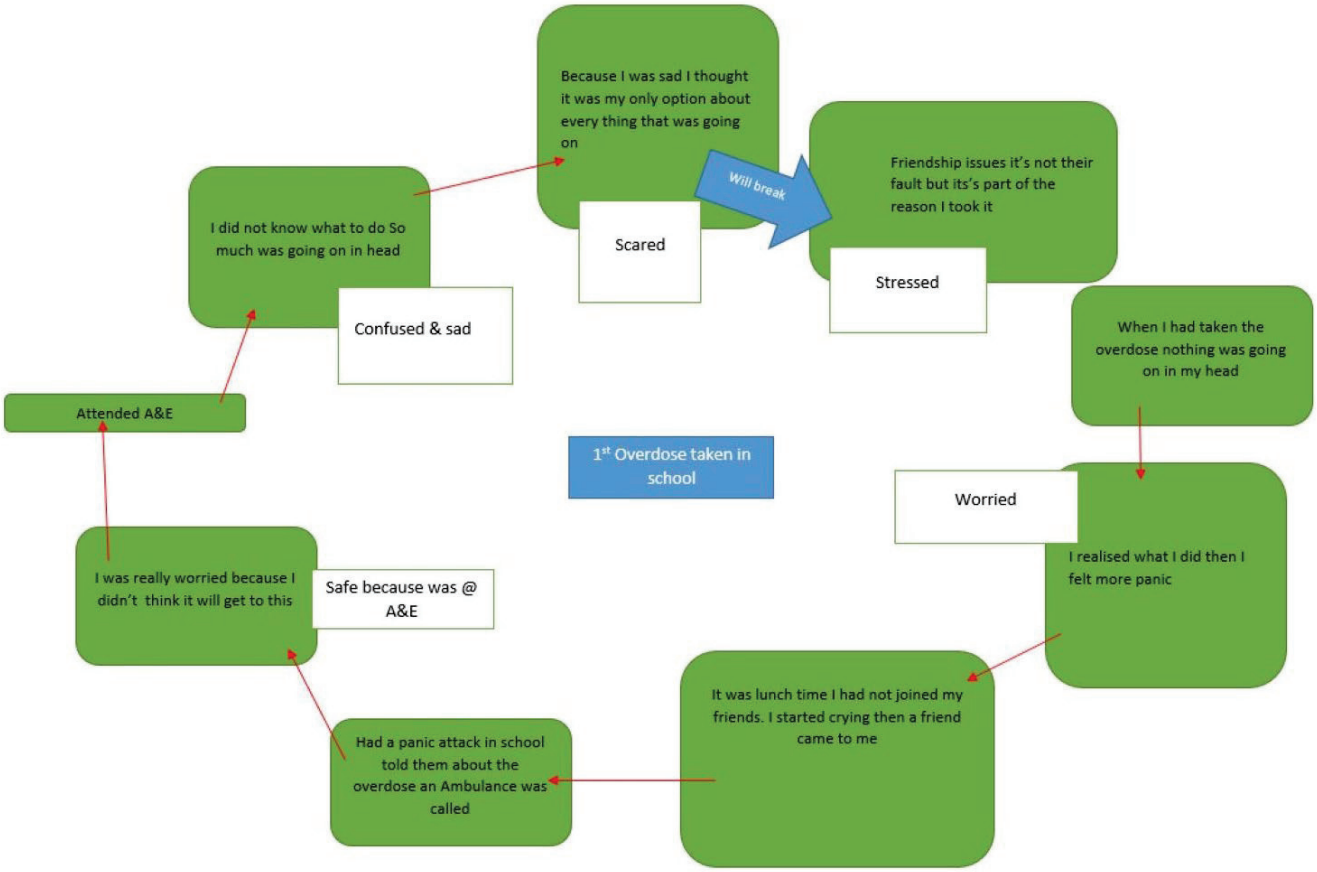

Figure 2. Self-harm cycle for Adah.

3.2. Case Study 2: Enhanced Safety Planning with Eliana

In most cases, the practitioner and YP conducted safety planning in the first session after completing the TA cycle. In some situations where more time was needed, the YP took the safety plan home to complete, while others completed it at the beginning of the second session. In routine care (or Treatment As Usual in the trial), a SP is discussed in the psychosocial assessment in the ED. SASH practitioners were advised to incorporate any previous elements of the ED safety plan into the SASH SP where relevant. Parents/carers were often brought into the session to discuss the safety plan with the practitioner and YP to support its use.

Case study 2 focuses on Eliana, who attended five sessions (one TA/SP session and four SFBT follow-up sessions). Eliana's issues were centred around school—they were not regularly attending school and found it difficult when they did. They were being seen by a broad range of professionals, including a family therapist.

The first section of the SP involves getting to know the YP, exploring what they are like when they are well and what they like to do, what helps them to stay well, and what might get in the way of this. This begins to build a picture of the YP's life, where they feel safe, who they trust, and what they feel their barriers are to feeling well (difficulties in their life). Getting to know the YP fosters a *therapeutic relationship* and helps to personalise the intervention. This YP commented on its comprehensiveness: "I liked how it's more detailed and I was able to add more to the plan rather than the one in the A&E one where it was just like more basic. . ..". SPs in the ED tend to focus on means restriction and generic signposting to crisis lines/support.

https://doi.org/10.3390/healthcare14020168

In the first section of the SP, the YP identified positive attributes of themselves, to begin to engender *positive emotions* and *identify their own strengths*. They described themselves as loud, confident, fun, easy to talk to, caring, reliable, funny, loyal, honest, and beautiful when they feel okay. When feeling okay, they described their preferred activities as drawing/art, listening to music, watching TikTok/shows, spending time with cousins, and taking a nap. To feel okay, the YP described that she needed sleep, to watch comfort shows, TikTok, and to talk to cousins on the phone. Reflecting on this helps the YP to begin to recognise that they can *use some of their own resources to make progress*. Barriers to feeling okay were identified as arguments, [feeling] physically unwell, bad relationships with friends, not being able to regulate emotions, and being around too many people.

Practitioners then support the YP to create a *granular safety plan with multiple coping strategies*. Eliana began by identifying warning signs of escalating distress, *building self-awareness of self-harm*, and the onset of thoughts of self-harm. Practitioners are encouraged to use a traffic light system to help the YP identify early warning signs before self-harm becomes too challenging to avoid. Eliana identified physical sensations (feeling extremely hot, head twitching slightly, mini panic attacks, fidgeting, picking fingernails, squeezing the palms of hands, negative thoughts (worthlessness, failure, and "don't deserve to be here"), and emotional changes (sudden mood changes and angry). Elian was usually in her bedroom or in public when this started and described a range of ways to distract herself: by watching a comforting show on Netflix, listening to music, drawing, and spending time with cousins. She felt she was likely to do this only sometimes, as she would be thinking, e.g., "I just need to hurt myself" and that her distress may burden others who are close to her. Eliana identified small steps to overcome these barriers, building *motivation and hope,* and ensuring the *strategies are realistic and actionable*. Small steps included managing low self-esteem with positive affirmations, building her confidence more by speaking to her parents, and talking to others. She noted new ways of thinking about herself and the importance of building herself up: "I can't please everyone, therefore the best person I can please is myself", suggesting a developing *sense of agency*.

YP then consider *ways to break the cycle of self-harm* by distracting themselves from escalating distress, specific to the setting in which the warning signs typically emerge. This YP identified walking in the local area, going to a place they like, such as the cinema or their cousin's house, or going to their bedroom. They described it as being very likely that they would use these techniques, but that feeling too distressed/overwhelmed, not wanting to ruin the fun, or pressure from the group might stop them. Small steps to overcome these barriers included improving self-esteem and confidence, limiting social anxiety, reading motivational quotes, and using countdown techniques.

In the final two sections of the SP, YP are prompted to *use their own resources to make progress* by identifying others whom they can contact as an alternative way of *breaking the cycle of self-harm* and increasing their *sense of agency*. This YP identified parents and family (cousins) as people to contact when feeling overwhelmed but noted that it was not very likely that they would contact them because they would feel like a burden, unheard, and judged. Small steps to overcome these barriers would be if close others were willing to listen and be understanding.

In the final stage, YP identify professionals whom they would contact when in distress, in order to build awareness of available *realistic and actionable coping strategies*. The YP described that they would be very likely to access a mixture of school (school counsellor and safeguarding network), healthcare (GP, A&E, and crisis line), and charity-based (Kooth, Young Minds, and Textline) professional support, but barriers would include the fear of being misunderstood or unheard. The YP reported that identifying what they would

https://doi.org/10.3390/healthcare14020168

discuss and imagining that the professional would be a listening ear would be ways to overcome these barriers.

3.3. Case Study 3: First Solution-Focused Brief Therapy Session with Charlotte

The first SFBT session follows the therapeutic assessment/safety plan session. Given the recent presentation to the ED with self-harm, this tended to also include a check-in on any self-harm/suicidal ideation or safeguarding issues that may have needed attention since the previous session.

The following session involves Charlotte, a girl, aged 14, who presented to the ED with suicidal thoughts (with recent self-harm). She was not attending school regularly.

- Best Hopes

The practitioner asks the opening question about *what is wanted by the YP:* "what are your best hopes from us talking?". Charlotte answers, "I don't know". Often, YP respond in this way. This is permission to ask another question. The practitioner asks again in lines 4–5, "what are you hoping to see?", and Charlotte responds, "Get better". The practitioner asks for clarification (lines 7–8), "what does getting better mean?", and Charlotte responds, "as in mentally". The practitioner asks for some further information (lines 12–13), and Charlotte responds, "trying to communicate better". This shows how the focus is on what Charlotte hopes to achieve (underlined text) rather than on the practitioner's agenda. This increases engagement in the session as it defines the agenda for the whole session. It moves the talk away from the problem to what is wanted. In this session, Charlotte hopes to feel mentally better and to communicate better (Figure 3).

1. PRA: So let's start by thinking, **what would you say your best hopes are from**
2. **us talking together?**
3. YP: **Don't know**
4. PRA: what are you hoping to see? What are you hoping that happens with us
5. talking together? **What are you hoping to get from this?**
6. YP: **Get better**
7. PRA: To get better. What- tell me a bit more about you, what- how do you- **what**
8. **does getting better mean?**
9. YP: **Like as in mentally.**
10. PRA: Okay.
11. ....
12. PRA: **What did you think that you will gain from, from us chatting or from you**
13. **you participating?**
14. YP: **Trying to like communicate better.**

Figure 3. Transcript excerpt from Charlotte's SFBT session: exploring best hopes.

The practitioner then asks a follow-up question below (lines 2–3) to the best hopes question, "what difference will it make?" if Charlotte is mentally better. This helps her to articulate the positive difference this will make in her life. Charlotte responds, "a lot of difference", and the practitioner asks for a description. Charlotte states she would be happy to go to school, socialise with people in school, and participate in lessons (lines 6–7) (Figure 4).

- Miracle Question

After establishing the person's best hopes, the next "miracle question" (lines 1–3 below) encourages Charlotte to *visualise a good day* when she is feeling mentally better. This prompts Charlotte to visualise a day when she is "mentally better" and provides descriptive details about what will be happening on this kind of day. Charlotte states she

would be "a lot happier" (line 4). By asking "how will you know you're a lot happier", the practitioner elicits a behavioural description: "if I have something to do, I would just get up and do it straight away" (lines 6–7). A further question, "How will you know that tomorrow is a day that you're feeling mentally better?" elicits further detail from Charlotte, "I'd go to school". Although this is a very similar question to the previous miracle question in lines 1–3, it elicits further behavioural description about how this will show in her life. The practitioner then asks a common SF question, "what else" (line 13), to encourage further description. The YP adds she would be "more social in general" (line 14) (Figure 5).

1. PRA: Then, let's say tomorrow. You woke up and you were no longer had any mental
2. health struggles. **What, what do you think would what difference do you think**
3. **that would make to you?**
4. YP: **A lot of difference.**
5. PRA: Tell me describe them.
6. YP: Like I'd be **happy to go to school. Probably like socialise with people in**
7. **school and participate in lessons.** That's all I can think of.

Figure 4. Transcript excerpt from Charlotte's SFBT session: the difference achieving her best hopes would make in her life.

1. PRA: So **let's say you woke up tomorrow and life**
2. **was the same, but you felt you were mentally better, what's the first tiny**
3. **thing you might notice when you wake up?**
4. YP: **Be, like, a lot happier.**
5. PRA: Okay. And how will you know you're a lot happier?
6. YP: Because **if I have something to do, I would just get up and do it straight**
7. **away**
8. PRA: Okay Anything else?
9. YP: No.
10. PRA: Okay tell me about what you noticed about this particular day. **How will**
11. **you know that tomorrow is a day that you're feeling mentally better?**
12. YP: **I'd go to school.**
13. PRA: Okay. **What else?**
14. YP: **I just be like more social in general erm that's all I can think of.**
15. PRA: And **what difference do you think being more social would make?**
16. YP: **Be happier.**
17. **....**
18. PRA: Okay. **Do you think if you're happier, generally, that means you will**
19. **continue to feel mentally better?**
20. YP: Yeah.
21. PRA: And stop you from feeling maybe sad or down?
22. YP: Mhm.
23. PRA: **Did you see how that was kind of an entire circle because you started**
24. **out with if you were to get mentally better, you'd be happier to go to school,**
25. **you'd socialise more. If you had something to do, you'd get up and do it**
26. **straight away. You'd be more productive and wouldn't be sleeping all day,**
27. **and you'd be more, you'd be participating more in school.** Which will
28. ultimately lead you to be happier and I guess one great way of being mentally
29. better is being happier.
30. Would you agree?
31. YP: **Yeah. Yeah.**

Figure 5. Transcript excerpt from Charlotte's SFBT session: the miracle question.

https://doi.org/10.3390/healthcare14020168

The SF questioning prompts Charlotte to describe getting up straight away if she has something to do, going to school, being more social, and participating more in lessons, all of which would make her feel happier. Asking questions that elicit detailed descriptions translates what "mentally better" would look like in Charlotte's day.

3.4. Case Study 4: Follow-Up Solution Focused Session with Wai

Follow-up SF sessions focus on what has been better and amplifying the person's resources, coping skills, and strengths. This follow-up session is with a YP called Wai, who is aged 16. Reflecting on the impact of the solution-focused sessions, Wai said she has "been a lot more calm in stressful situations. . ." The opening question in a follow-up SF session is "What has been better?". This directs Wai to *notice small signs of progress*, as described in the logic model. In the transcript below, Wai responds that she has become more comfortable with her surroundings, her school, and has got closer to people. The practitioner invites Wai to elaborate further in lines 5–6, "In what way?". Wai describes meeting with a friend between classes and opening up to her about her self-harm and how she was feeling. Wai describes how it felt nice to share how she was feeling with her friend, as it was mutual because she usually worries about pushing people away or sharing too much (lines 21–24) (Figure 6).

1. PRA: **What's been better since we last saw each other?**
2. YP: Erm I think I've gotten more comfortable with my surroundings because
3. obviously, I just moved here and I think I've gotten closer to people and more
4. comfortable with school and stuff.
5. PRA: **Feeling more comfortable with your surroundings and with school okay. In**
6. **what way?**
7. YP: Like a friend her name's [name] we don't have any classes together
8. but during free period we meet up with each other and we're fairly open with
9. each other, like when we first met we've just always been open with each other
10. because she opened up to me about her self-harm and her family situation and
11. I felt safe to tell her about mine.
12. PRA: Okay. And is this a recent friend, with (friend), a recent friendship or?
13. YP: Oh, yeah we met each other when I first got to the college.
14. .....
15. PRA: Okay, and then that kind of triggered you to open up?
16. YP: Yeah
17. PRA: And feel comfortable to open up about how you were feeling. And how was
18. that?
19. YP: Err it was nice yeah.
20. PRA: Yeah and how did you feel afterwards?
21. YP: Yeah it felt nice because usually when I tell someone about how I'm feeling,
22. I worry about maybe I'm pushing them away, or maybe that was too much to
23. share, but it was nice that she started sharing first. So I felt because she's doing
24. the same thing I was doing, so it felt like mutual.
25. PRA: Mutual?
26. YP: Yeah.

Figure 6. Transcript excerpt from Wai's follow-up SFBT session: describing what has been better since the last session.

When the practitioner asks Wai what was there instead of worry (line 30), the YP responds that there was reassurance. This draws out *exceptions to the problem*, namely how Wai is able to share how she feels and feel reassured rather than worried. The practitioner asks what it was about how Wai's friend responded that helped her feel reassured (33–34).

https://doi.org/10.3390/healthcare14020168

Wai describes how her friend tried to understand what she was going through rather than asking her why she felt that way or why she did what she did (Figure 7).

27. PRA: **So that worry about kind of pushing people away, kind of putting people off,**
28. that wasn't there?
29. YP: No.
30. PRA: **What do you think was there instead of that?**
31. YP: Like reassurance
32. ....
33. PRA: **Okay and what was it about [friend's] responses or the**
34. way she looked, anything that helped you to feel reassured?
35. YP: She asked questions to try to understand what I'm going through instead of
36. thinking, like why did you feel that way, why did you do that.

Figure 7. Transcript excerpt from follow-up SFBT session with Wai: exceptions to the problem.

The practitioner then returns to Wai's description of being better at the beginning of the session, "feeling more comfortable with my surroundings", and asks her to elaborate further. This activity is *amplifying signs of progress*. Wai describes feeling more comfortable with the area (as she had recently moved there), along with feeling more comfortable with her classmates and being around them and being able to talk to them. When Wai describes how other students were "strangers" at first (lines 46–47), the practitioner asks what she could call them now, rather than strangers. Wai responds, "peers, classmates". These questions elicit Wai's personalised descriptions of how "more comfortable" is happening in her life (Figure 8).

37. PRA: **So it sounds like you're starting to feel a lot more comfortable in your**
38. surroundings and in school. When you said surroundings what- what else
39. did you mean aside from school?
40. YP: Like I don't know, I feel more comfortable with the area.
41. PRA: Yeah.
42. YP: I know where the things are.
43. PRA: You've become used to it?
44. YP: Yeah and like with school in class with my classmates, I feel more
45. comfortable to be around them because obviously, when I first got here, they were
46. strangers to me.
47. PRA: Yeah.
48. YP: But now, like, I, I know them more and I'm comfortable to be around them
49. and be able to talk to them.
50. PRA: **What would you call them now if not strangers?**
51. YP: Peers, classmates.

Figure 8. Transcript excerpt from Wai's follow-up SFBT session: amplifying signs of progress.

In the following excerpt, the practitioner asks Wai what she has learned about herself. Wai describes a specific set of events that led to her breaking point (lines 56–60) when her old best friend said he did not care about her. The practitioner then asks about *coping strategies:* "that sounds really challenging. Kind of when he approached you, and said what he said, how did you cope?" (lines 65–66). Wai describes that previously she felt that he was a person who cared about her and that she "realised that he's not and that, like, I don't mean much, if not anything to him now". She describes this realisation as helping her not to be pushed to her breaking point (Figure 9).

https://doi.org/10.3390/healthcare14020168

52. PRA: Peers, classmates? Okay. **And what have you learned about yourself in**
53. **this, in this kind of short period, where you're becoming more comfortable**
54. **with your surroundings in the school?** What have you been learning about
55. yourself?
56. YP: Erm I'm not sure. I think that I only, like, get to my breaking point when
57. someone pushes me over it. So when I tried to commit, my breaking point was
58. when- I didn't put myself in my breaking point, my old best friend pushed me
59. over the edge by saying that he didn't care about me, even though I tried to ask for
60. help.
61. PRA: There was a very specific set of events that led to that kind of breaking
62. point.
63. YP: Yeah.
64. .....
65. PRA: O**kay, that sounds really challenging and kind of when he approached you**
66. that other time, and said what he said, how did you cope?
67. YP: For which time?
68. PRA: For the more recent time.
69. YP: Erm, I don't know, I just, at that point because the first time he was very
70. important to me, and I felt like he was a person who would care about me most.
71. This time I realized that he's not and that, like, I don't mean much, if not anything to
72. him now.
73. PRA: Okay and that and that helps in the situation, that helps you cope?
74. YP: Yeah.

Figure 9. Transcript excerpt from Wai's follow-up SFBT session: identifying coping strategies.

- Scaling Questions

To identify what is already working is commonly used in SFBT. The practitioner asks in lines 2–4 below, "imagine that like on scale of 0 to 10, 10 means that your best hope has been realized so in this case, 10 completely, 0 the opposite where do you think you'd put yourself?". Wai responds, "four". The focus is on why Wai is where they are on the scale *and not lower*. Wai states that she understands her emotions quite well: She knows why she feels the way she does, and she overthinks. She is starting to accept it but has not fully accepted it fully yet. The practitioner reiterates that she is a "four" because of that "sense of understanding", then explores *small signs of progress* by asking Wai what would be different if she were one point up—a five on the scale (lines 13–16). Wai describes not feeling like she needs validation or to talk to other people if she is feeling upset: Rather, she would be feeling okay by herself (lines 20–28) (Figure 10).

3.5. Case Study 5: Solution Focused Session with Carer Michelle

Sessions are offered to carers if they would like to avail of them. Sessions can be for one or more carers. In interviews, practitioners noted that these sessions gave a space for carers to talk, reflect on supporting themselves and their mental health, helped bridge understanding between them and their son/daughter, and sometimes were a space to reflect on their own experiences of growing up, their relationships with their parents/carers, along with diverse cultural approaches to parenting. Practitioners found that identifying where the YP and their carer have some shared aspect in their best hopes can provide a basis for improved relationships, which are often strained by the crisis. Given that relationship problems between family members are commonly reported problems in YP who self-harm [29], this may contribute to a reduction in the risk of repeated self-harm. A practitioner reflected on the impact of improved understanding among YP and carers and offering targeted support to carers: "every single dynamic of YP and parent I've

https://doi.org/10.3390/healthcare14020168

worked with have had a transformed dynamic by the end of the intervention. . . the YP may be the one who is self-harming, but the parent is often also in crisis".

PRA: If we were to- do you remember that kind of rating question or the scaling question....**imagine that like on scale of 0 to 10, 10 means that your best hope has been realized so in this case, 10 being completely on top of your emotions, 0 the opposite, where do you think you'd put yourself today?**
YP: Four.
PRA: Four. Why a four and not a three?
YP: Because I think I **understand my emotions quite well,** I think that I know why I feel this way, I know the things- I like to overthink, so I like to connect things.
PRA: Yeah.
YP: So like I connect different events to what happened, how I feel this way why I feel this way. **I think I understand that pretty easily, it's just trying to accept it. I think I'm starting to accept but I haven't fully.**
PRA: Okay okay. **So you're four because, like, that sense of understanding is pretty much there. And then the next step for you maybe is thinking about acceptance and focusing on that. So if we would catch up again next week or a couple of weeks if you answered by saying I'm five, what would need to be different?**
YP: I'm not sure
PRA: W**hat little things would need to be going on for you to think, yeah you know what, I'm going in that direction, I'm getting closer to achieving that best hope?**
YP: I guess **not needing validation from other people.** And like, I know humans aren't built to live in solitude and that's why we live as a community to help each other, but I shouldn't be dependent on other people, and **I should be okay with being alone.**
...
YP: I think that with (friend), I like to be open with her and to be close with her, **but I shouldn't need to depend on her to feel okay. Like if I, I am upset I shouldn't need to talk to other people for me to be okay. I should understand how to make myself like, how to kind of feel okay by myself.**

Figure 10. Transcript excerpt from Wai's follow-up SFBT session: scaling question.

In the following SFBT session with Michelle, she describes her best hopes of "having an outlet", "being able to talk", "get things off my chest", "being able to speak about how it impacts on me", and "process how I'm feeling and what I'm holding". The practitioner also explores her best hopes for her daughter Wai (83–84), which are for her "to be safe" and "finish her education safely" (line 85) (Figure 11).

The practitioner then asks, "what difference do you think that would make to you if you were able to talk and have a safe outlet?" (lines 104–105). In SFBT, it is very important to use the person's exact words. This question helps Michelle to describe how the desired changes would impact tangibly on her life: This would lead to her feeling better. The practitioner asks Michelle to describe "what better looks like". Michelle responds that it would be "sleeping better" and "being calm in situations". Again, the practitioner uses Michelle's words ("if you were feeling better, sleeping better, able to remain calmer and deal with these situations better, what do you think that would lead to in your life?"). Michelle describes "less stress" (115) and "less anxiety" (117). Michelle then describes her morning after she has slept better, including that her daughter "works well when you're

https://doi.org/10.3390/healthcare14020168

not on top of her" (135–136). If Michelle has slept better, this would also have an impact on her daughter in the morning before they start their (Figure 12).

68 PRA: **What your hopes are from, from us having this meeting, this session,**
69 CAR: Sometimes **it's just good to be able to talk. Just let out what I've got, cos**
70 **obviously I don't really have an outlet.**
71 PRA: Yeah
72 CAR: Sometimes it's just helpful for me I mean I find it helpful. We have family
73 therapy, but there are a lot of things obviously that I can't bring actually, because
74 that's not what that session is for. It's, **I guess it's just, it's just nice to be able**
75 **to get things off my chest.**
76 PRA: Yeah. And I guess what kind of things that you, that you would find
77 helpful to get off your chest?
78 CAR: **Just being able to speak about how it impacts on me.**
79 So I guess just being able to **process how I'm feeling and what I'm holding in**
80 because I do hold a lot in just because I need to be able to instil confidence.
81 PRA: Mm yeah. So I guess…
82 CAR: Ermmm
83 PRA: What would be, if, **what would be your best hope for [daughter], what are your**
84 **hopes for her?**
85 CAR: **Just to be safe. To be safe, to be able to finish her education safely.**

Figure 11. Transcript excerpt of parent/carer SFBT session with Michelle: Michelle's best hopes.

The practitioner then asks Michelle what she is already doing to get a good night's sleep (lines 300–301 below). This directs Michelle to *notice what is already working.* Michelle reports going to the gym and having an evening for herself. When the practitioner asks, "Anything else", this elicits further information about positive things Michelle is already doing: Michelle puts on calming music/YouTube and goes running. The practitioner then asks *strategy* questions: "how did you go about managing to implement these things? What did it take for you to do these things?" (lines 309–310). These questions elicit Michelle's resources ("I know it helps me so I just push myself"—line 320) and what she is already doing to achieve her best hope of "sleeping better" so that she is "feeling better" (Figure 13).

These brief SFBT excerpts illustrate some of the techniques and questions that are used to focus on what the YP or carer wants to be better (their best hopes) and what will be happening if their best hopes are achieved (their preferred future). The conversations show how practitioners attend closely to the YP/carer's exact words. This supports shared understanding and collaborating closely with the YP and carer in.

https://doi.org/10.3390/healthcare14020168

104 PRA **if you were able to talk and have a safe outlet of the things that you've kind of**
105 **got built up within you, what difference do you think that would make to you?**
106 CAR: Well I know before, I had counselling before, umm, that was helpful having
107 that outlet every week **was making me feel a lot better** umm.
108 PRA: When you mean **when you say feel better, describe what that better looks like.**
109 CAR: **Sleeping better** I was able to sleep better. I was able to remain I wouldn't
110 say remain calmer I was **calm in situations**, I was able to **deal with situations**
111 **better**.
112 PRA: Yeah, okay. And, I **guess if you were, feeling better, sleeping better, able to**
113 **remain calmer and deal with these situations better. What do you think that**
114 **would lead to in your life?**
115 CAR: **Less stress, uh less stress.**
116 PRA: Anything else?
117 CAR: Maybe **less anxiety** as well.
118 PRA: It would relieve, did you say it would relieve your anxiety?
119 CAR: Yeah.
120 PRA: Okay. So I know that you mentioned kind of five differences that you, that
121 you could envision happening if you found this safer place to have an outlet
122 and that being feeling better, sleeping better, remaining calm and dealing with
123 situations better, having less stress and having more relief from your
124 anxieties. Of the five, which one would you say is probably the most important
125 or the most present for you at the moment?
126 CAR: Maybe the sleep, sleeping better.
127 PRA: Okay. So it would be nice to then think about. **If I was to say that you woke up**
128 **tomorrow. And life was still the same. But you had a very good night's sleep.**
129 **You had a very restful night. What's the first thing you will notice when you**
130 **wake up?**
131 CAR: **Just be waking up with less anxiety** more than anything. Or
132 my brain, my brains not running so well trying to think of a million things.
133 PRA: And tell me what a normal morning routine looks like for you.
134 CAR: I'm usually up and then when I'm up I feed the cat straightaway, start doing
135 my lunch, **usually um cos [daughter] works well when**
136 **you're not like on top of her like, oh you need to do this, this and this today.** She
137 works better when she's got it in the morning when I wake up, cos she's
138 usually asleep when I wake up in the morning, I'll give her a text in the morning
139 saying, morning you've got this, this and this today and you've got these
140 appointments, do them today....

Figure 12. Transcript excerpt from Michelle's follow-up SFBT session: exploring the difference achieving her best hopes would make.

https://doi.org/10.3390/healthcare14020168

300 PRA **What would you say you're already doing that's supporting you with getting a**
301 **good night's sleep?**
302 CAR: I go to the gym. That helps. And on a Monday I make it my kind of evening
303 on a Monday. Yeah. So I keep Monday free so I can make sure I can do
304 that for myself.
305 PRA: **Anything else you're doing to aid support your sleep.**
306 CAR: Sometimes I put on my really, try and put some calming music on, or put
307 YouTube on or like go running.
308 PRA: Oh that's cute. Okay. And I guess **how did you manage to go about**
309 **implementing these things? What did it take for you to do these things?** To
310 notice that they had an effect to on you gaining better sleep?
311 CAR: I've always I mean, I work with students, so, sometimes we have things like
312 on for them. And then I will be like, oh, this is really calming space. Yeah. Its
313 just things I've picked up along the way really. But I know that when I finish,
314 like, gym, I know when I've done gym, I feel really good. I can feel
315 super tired. I go to the gym or come back out like that, and I feel great.
316 PRA: And I guess **how have you managed to continue upholding these things when**
317 **it probably felt like you didn't want to,** but yet you kind of pushed yourself to
318 do it anyway because you just...
319 CAR: I just, yeah, **I know it helps me so I just push myself** to do it. Even though I
320 don't get me wrong, there are days where I just go uh, I don't want to do gym
321 today, but I still like you know feel good afterwards.

Figure 13. Transcript excerpt from Michelle's follow-up SFBT session: encouraging Michelle to notice what is already working.

4. Discussion

The intervention materials and session transcripts illustrate how the SASH intervention can support YP to (1) better understand *their personal* self-harm and identify ways of breaking the cycle of self-harm, (2) develop a highly *personalised and granular safety plan* with a range of coping strategies, and (3) identify their *personal hopes* for what they want to be better in their lives and how they are already moving in this direction. All three components prioritise the YP's or carer's language and use their words to formulate the cycle of self-harm, the safety plan, and hopes for/progress towards their preferred future. The collaborative approach fosters the therapeutic relationship and personalised care.

Across the sessions, some core themes emerged. The role of friendships for young people, particularly at school, was important in both negative and positive ways. Experiencing difficulties with friends at school led to feelings of sadness and stress, which could become overwhelming, leading to thoughts of self-harm ("I just need to hurt myself") and triggering self-harm behaviour. YP described noticing mood changes and signs that they were becoming stressed, which improved their self-awareness and understanding of the link between their feelings and self-harm behaviour. They reflected on what kept them feeling calm and overcoming a fear of being a burden on others by sharing how they were feeling, which helped them not to self-harm. They also described difficult feelings stemming from a need to please everyone or needing validation from others: Overcoming these feelings led to less social anxiety and more confidence. This led to finding it easier to go to school and being more social with friends/student peers, which in turn improved their mood

https://doi.org/10.3390/healthcare14020168

In the TA case study of Adah, drawing the cycle of self-harm helped the YP to unpack the "core pain" behind their self-harm (sadness) and how this led to self-harm ("I thought it was only option"). Breaking down the chain of events and asking the YP to consider the positive short-term consequences (relief as "nothing going on in my head") and then the negative longer-term consequences (a panic attack and having to attend the ED) helps the YP to understand the link between their emotions and behaviour. Developing a detailed personalised trajectory enables the YP to explore where *they* feel it would be helpful to think about breaking the cycle. This contrasts with more generic advice about stopping self-harm and reflects the logic model mechanisms of change, namely building the YP's self-awareness of their self-harm and instilling confidence in how to break the cycle. Synthesis of accounts of people who reduced or stopped self-harming reveals the importance of breaking the link between an individual's psychological or social states and self-harm behaviour [30]. YP report being given advice that they do not feel is relevant for them [31]. Previous research has found the Therapeutic Assessment to be effective in improving engagement in subsequent follow-up care [32]. In this case, the YP attended four further sessions after the TA, indicating good engagement in the SASH intervention.

The SP case illustrates an initial focus on what the YP is like when they are well. This addition to the SP was suggested by our Young Person Advisory Group (YPAG) who we collaborated with during the SASH trial. This is consistent with a more positively framed approach, similar to the Reasons for Living approach, which focuses on positive reasons for staying alive in YP admitted to the hospital [33]. Enhanced Safety Planning is a very granular approach. YP identify *their* own personal warning signs (thoughts, emotions, and body sensations), where they typically are when these signs appear, and a range of coping strategies they can draw on in these moments. It incorporates principles of behaviour change by explicitly asking about barriers to implementing helpful behaviours and reaching out to others when things are starting to deteriorate and how to overcome these barriers.

While SP are recommended in NICE guidelines following an episode of self-harm [1], they typically provide basic information about means restriction and crisis phone numbers. Although there is little research on YP's experiences of safety planning, adults have described safety plans as too generic and not sufficiently personalised to them [34]. Patients often report doubts about being able to use their safety plan [35]. This reflects the importance of troubleshooting barriers to using the coping strategies and thinking these through before the person is going into or in a crisis: Adah described saying positive affirmations to herself in these moments. These strategies provide new ways of thinking, which support the YP's motivation and hope that they can break the self-harm cycle.

SFBT sessions focus on the YP's or carer's best hopes for the future (rather than problems) and current strengths. They generate positive emotions by visualising and describing a good day, identifying what is already working, noticing exceptions to the problem, and orienting the YP/carer to notice small signs of progress. Similar to TA and SP, SFBT elicits personalised, detailed descriptions about the YP/carer's situation. In Case study 3, Charlotte describes wanting to get better mentally and to communicate better. Her visualisation and detailed description of a good day starts with her getting straight out of bed in the morning and being happier to go to school and socialise more with people. This would make her happier, which in turn would make her mentally better. The transcripts of the SFBT sessions show how questions elicit detailed descriptions of what will be happening in the person's daily life when things are better [36].

SFBT has been used with people with suicidal thoughts or in a mental health crisis [37]. By focusing on the person's strengths and resources, it helps to instil hope [37]. SF approaches have also been used in the assessment and [37,38] management of suicide risk,

https://doi.org/10.3390/healthcare14020168

albeit more commonly in adults [39]. A solution-focused approach is a paradigm shift from the usual way of working in crisis mental health care in the NHS. However, it can be embedded within NHS systems of care and in the context of self-harm and suicide risk management [40].

Supporting carers is increasingly recognised as an important part of care for YP presenting to the ED with self-harm in a mental health crisis. Recent clinical and practice reviews recommend greater attention paid to family involvement [7,18]. Meanwhile, Mughal et al. (2022), in their systematic review of the needs of individuals supporting YP, found that they also need support, especially as they negotiate new identities when handling self-harm in YP [41].

Strengths and Limitations

This paper presents five case studies based on materials and recordings of the SASH intervention sessions, which were collected as part of a process evaluation in an ongoing randomised controlled trial. The intervention was implemented in routine clinical settings in the NHS in the UK. Clinical and other outcomes (e.g., depression, anxiety, wellbeing, and school attendance) are assessed after 6 months, and the primary outcome is self-harm. The trial will also consider service use, costs to carer, and carer health-related quality of life to evaluate the costs and cost-effectiveness of the intervention.

As described by McLeod (2010) [27], this is useful for demonstrating how psychological interventions are delivered in practice and provides practitioners with real examples of working with YP presenting with self-harm. We used case materials from medical records and intervention recordings to illustrate components of the SASH intervention delivered by child and adolescent mental health practitioners. While the RCT results have not yet been published, this study offers insights into real-world treatment, providing fine-grained and practice-based evidence of how the SASH intervention was delivered to YP in crisis. This offers valuable information for clinicians on how the SASH techniques were implemented in real clinician-patient interactions. Multiple sources of data, including intervention session transcripts, bespoke intervention materials, and qualitative interviews, are used to demonstrate the delivery of the intervention in practice. The logic model provides a structured conceptual framework for interpreting potential mechanisms of change of the intervention. While we only presented five case studies, there was cultural diversity in the cases described.

Limitations relate to the availability of intervention session recordings and sampling of the cases. Intervention sessions were sampled according to availability, audio quality, and fidelity to the intervention according to the manual. Only n = 16 intervention sessions were recorded among 78 participants. Consent from the young person, carer, and practitioner was required, and in many cases, consent to recording was not given by one or all parties. Future studies could further encourage the recording of intervention sessions in research studies.

Only five case studies were presented, which may not capture the variation in implementation across different groups of YP and may not be representative of the broader pool of intervention sessions. Once the trial results are available, it will be important to consider the clinical and service use outcomes of the YP in the SASH intervention compared to those receiving Treatment As Usual. Given the link between ED self-harm presentations and the risk of future suicide, re-presentations to the ED will be of particular interest. In addition, data on YP engagement in the intervention, YP who dropped out, and the number of sessions attended will provide insights into the acceptability of the intervention. The SASH trial recruited YP and carers from nine EDs in London. All of the case studies were based on YP who were female (and cis gender). This reflects the overall SASH sample,

https://doi.org/10.3390/healthcare14020168

which was predominantly female. None of the current case studies included YP who were neurodivergent or gender diverse. This may limit the generalisability of the findings to a more diverse group of YP and carers.

5. Conclusions

These case studies demonstrate how YP improved their self-awareness and understanding of the link between feelings and self-harm behaviour and identified ways of breaking the self-harm cycle, along with detailed strategies for managing difficult feelings and situations at school and with friends. The carer case study demonstrates the potential to support carer mental health so they can, in turn, better support their YP's mental health. Supporting YP and carers in this way has the potential to reduce the risk of future self-harm.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/healthcare14020168/s1, Figure S1: Therapeutic Assessment: cycle of self-harm; Figure S2: enhanced safety plan template; Figure S3: solution-focused brief therapy template (first session); Figure S4: solution-focused brief therapy template (follow-up session).

Author Contributions: Conceptualisation, R.M., M.L. and S.O.; Methodology, R.M., M.L. and S.O.; Data analysis, R.M., M.L. and S.O.; Writing manuscript, R.M., M.L. and S.O.; Project management, R.M., M.L. and S.O. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by the Kavli Trust. SO'K is funded by the National Institute for Health and Care Research (NIHR) Applied Research Collaboration North East and North Cumbria (NIHR200173). The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Institutional Review Board Statement: This study was conducted in accordance with the Declaration of Helsinki and approved by the London-Riverside Research Ethics Committee (Ref: 22/LO/0400 on 23 August 2022).

Informed Consent Statement: Informed consent was obtained from all subjects involved in this study.

Data Availability Statement: The original contributions presented in this study are included in the article. Further inquiries can be directed to the corresponding author.

Conflicts of Interest: The authors declare no conflicts of interest.

References

1. Self-Harm: Assessment, Management and Preventing Recurrence NICE Guideline. 2022. Available online: https://www.nice.org.uk/guidance/ng225/evidence/p-skills-required-by-staff-in-specialist-settings-pdf-403069580827 (accessed on 19 December 2025).
2. Butt, S.; Randall, E.; Morris, S.; Appleby, L.; Hassiotis, A.; John, A.; McCabe, R.; McManus, S. Suicidal thoughts, suicide attempts and non-suicidal self-harm. In *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4*; NHS England: London, UK, 2025.
3. WHO. *Suicide Worldwide in 2021: Global Health Estimates*; WHO: Geneva, Switzerland, 2025.
4. Appleby, L.; Kapur, N.; Shaw, J.; Hunt, I.; Ibrahim, S.; Gianatsi, M.; Rodway, X.; Williams, A.; Tham, S.; Raphael, J. *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*; Healthcare Quality Improvement Partnership: London, UK, 2017.
5. Cadorna, G.; Vera San Juan, N.; Staples, H.; Johnson, S.; Appleton, R. Review: Systematic review and metasynthesis of qualitative literature on young people's experiences of going to A&E/emergency departments for mental health support. *Child Adolesc. Ment. Health* **2024**, *29*, 266–275. [CrossRef] [PubMed]
6. Owens, C.; Hansford, L.; Sharkey, S.; Ford, T. Needs and fears of young people presenting at accident and emergency department following an act of self-harm: Secondary analysis of qualitative data. *Br. J. Psychiatry* **2016**, *208*, 286–291. [CrossRef] [PubMed]
7. Witt, K.; Stewart, A.; Hawton, K. Practitioner Review: Treatments for young people who self-harm—Challenges and recommendations for research and clinical practice. *J. Child Psychol. Psychiatry* **2025**, *66*, 122–131. [CrossRef]

8. Ougrin, D.; Zundel, T.; Ng, A. *Self-Harm in Young People: A Therapeutic Assessment Manual*; CRC Press: Boca Raton, FL, USA, 2009.
9. English, O.; Wellings, C.; Banerjea, P.; Ougrin, D. Specialized Therapeutic Assessment-Based Recovery-Focused Treatment for Young People with Self-Harm: Pilot Study. *Front. Psychiatry* **2019**, *10*, 895. [CrossRef] [PubMed]
10. Abbott-Smith, S.; Ring, N.; Dougall, N.; Davey, J. Suicide prevention: What does the evidence show for the effectiveness of safety planning for children and young people?—A systematic scoping review. *J. Psychiatr. Ment. Health Nurs.* **2023**, *30*, 899–910. [CrossRef]
11. Kennard, B.; Mayes, T.; King, J.; Moorehead, A.; Wolfe, K.; Hughes, J.; Castillo, B.; Smith, M.; Matney, J.; Oscarson, B.; et al. The Development and Feasibility Outcomes of a Youth Suicide Prevention Intensive Outpatient Program. *J. Adolesc. Health* **2019**, *64*, 362–369. [CrossRef]
12. Lewis, P. Reaching the Tipping Point. Children and Young People's Mental Health. Mental Health Network NHS Confederation. 2021. Available online: https://www.nhsconfed.org/publications/reaching-tipping-point (accessed on 6 February 2023).
13. NHS Digital. Waiting Times for Children and Young People's Mental Health Services, 2023–2024. 2025. Available online: https://digital.nhs.uk/supplementary-information/2025/waiting-times-for-children-and-young-peoples-mental-health-services-2023-24 (accessed on 19 December 2025).
14. Malla, A.; Shah, J.; Iyer, S.; Boksa, P.; Joober, R.; Andersson, N.; Lal, S.; Fuhrer, R. Youth Mental Health Should Be a Top Priority for Health Care in Canada. *Can. J. Psychiatry* **2018**, *63*, 216–222. [CrossRef]
15. Punton, G.; Dodd, A.L.; McNeill, A. 'You're on the waiting list': An interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK. *PLoS ONE* **2022**, *17*, e0265542. [CrossRef]
16. Young Minds. Mental Health Waiting Times Harming Young People. Online Press Release. Available online: https://www.youngminds.org.uk/about-us/media-centre/press-releases/mental-health-waiting-times-harming-young-people/ (accessed on 19 December 2025).
17. Gingerich, W.J.; Peterson, L.T. Effectiveness of Solution-Focused Brief Therapy: A Systematic Qualitative Review of Controlled Outcome Studies. *Res. Soc. Work. Pract.* **2013**, *23*, 266–283. [CrossRef]
18. Meza, J.I.; Zullo, L.; Vargas, S.M.; Ougrin, D.; Asarnow, J.R. Practitioner Review: Common elements in treatments for youth suicide attempts and self-harm—A practitioner review based on review of treatment elements associated with intervention benefits. *J. Child Psychol. Psychiatry* **2023**, *64*, 1409–1421. [CrossRef]
19. McCabe, R.; O'Keeffe, S.; Ougrin, D.; Priebe, S.; Martin, P.; Feng, Y.; Temple, R.; Long, M. Protocol of a randomised controlled trial of a novel brief psychological intervention for young people presenting to emergency departments in the UK with self-harm or suicidal ideation with recent self-harm: The SASH study (Supporting Adolescents with Self-Harm). *BMJ Open* **2025**, *15*, e101015. [CrossRef] [PubMed]
20. Stanley, B.; Brown, G.K. Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cogn. Behav. Pract.* **2012**, *19*, 256–264. [CrossRef]
21. Franklin, C.; Ding, X.; Kim, J.; Zhang, A.; Hai, A.H.; Jones, K.; Nachbaur, M.; O'Connor, A. Solution-Focused Brief Therapy in Community-Based Services: A Meta-Analysis of Randomized Controlled Studies. *Res. Soc. Work. Pract.* **2024**, *34*, 265–276. [CrossRef]
22. Creswell, C.; Violato, M.; Fairbanks, H.; White, E.; Parkinson, M.; Abitabile, G.; Leidi, A.; Cooper, P.J. Clinical outcomes and cost-effectiveness of brief guided parent-delivered cognitive behavioural therapy and solution-focused brief therapy for treatment of childhood anxiety disorders: A randomised controlled trial. *Lancet Psychiatry* **2017**, *4*, 529–539. [CrossRef]
23. Franklin, C.; Sucher, K.; Kim, J.S. Solution-focused brief therapy core elements and the process of change. In *Solution-Focused Brief Therapy with Families: A Training Manual*; American Psychological Association: Washington, DC, USA, 2025; pp. 23–49. [CrossRef]
24. Franklin, C.; Guz, S.; Zhang, A.; Kim, J.; Zheng, H.; Hai, A.H.; Cho, Y.J.; Shen, L. Solution-Focused Brief Therapy for Students in Schools: A Comparative Meta-Analysis of the U.S. and Chinese Literature. *J. Soc. Social. Work. Res.* **2022**, *13*, 381–407. [CrossRef]
25. Carr, A.; Hartnett, D.; Brosnan, E.; Sharry, J. Parents Plus Systemic, Solution-Focused Parent Training Programs: Description, Review of the Evidence Base, and Meta-Analysis. *Fam. Process* **2017**, *56*, 652–668. [CrossRef]
26. Gong, H.; Hsu, W. The Effectiveness of Solution-Focused Group Therapy in Ethnic Chinese School Settings: A Meta-Analysis. *Int. J. Group Psychother.* **2017**, *67*, 383–409. [CrossRef]
27. McLeod, J. *Case Study Research: In Counselling and Psychotherapy*; SAGE Publications Ltd.: London, UK, 2010. [CrossRef]
28. Willcox, G. The Feeling Wheel. *Trans. Anal. J.* **1982**, *12*, 274–276. [CrossRef]
29. Hawton, K.; Bergen, H.; Waters, K.; Ness, J.; Cooper, J.; Steeg, S.; Kapur, N. Epidemiology and nature of self-harm in children and adolescents: Findings from the multicentre study of self-harm in England. *Eur. Child Adolesc. Psychiatry* **2012**, *21*, 369–377. [CrossRef]
30. Brennan, C.A.; Crosby, H.; Sass, C.; Farley, K.L.; Bryant, L.D.; Rodriquez-Lopez, R.; Romeu, D.; Mitchell, E.; House, A.O.; Guthrie, E. What helps people to reduce or stop self-harm? A systematic review and meta-synthesis of first-hand accounts. *J. Public Health* **2023**, *45*, 154–161. [CrossRef]

31. Wadman, R.; Nielsen, E.; O'Raw, L.; Brown, K.; Williams, A.J.; Sayal, K.; Townsend, E. "These Things Don't Work." Young People's Views on Harm Minimization Strategies as a Proxy for Self-Harm: A Mixed Methods Approach. *Arch. Suicide Res.* **2020**, *24*, 384–401. [CrossRef] [PubMed]
32. Ougrin, D.; Boege, I.; Stahl, D.; Banarsee, R.; Taylor, E. Randomised controlled trial of therapeutic assessment versus usual assessment in adolescents with self-harm: 2-year follow-up. *Arch. Dis. Child.* **2013**, *98*, 772–776. [CrossRef] [PubMed]
33. Ugueto, A.M.; O'Hagan, L.A.; Lucassen, M.F.G. Reasons Why Suicidal Adolescents Want to Live: A Corpus-Driven Language Analysis. *Psychiatr. Serv.* **2025**, *76*, 951–958. [CrossRef] [PubMed]
34. O'Keeffe, S.; Suzuki, M.; McCabe, R. An Ideal-Type Analysis of People's Perspectives on Care Plans Received from the Emergency Department following a Self-Harm or Suicidal Crisis. *Int. J. Environ. Res. Public Health* **2023**, *20*, 6883. [CrossRef]
35. Hollenberg, E.; Shin, H.D.; Reid, N.; Stergiopoulos, V.; Lestage, L.; Nicoll, G.; Walji, A.; Zaheer, J. Context, Timing and Individualized Care: A Realist Evaluation of Safety Planning for Individuals Living with Suicide-Related Thoughts and Behaviours, Their Families and Friends and Service Providers. *J. Clin. Med.* **2025**, *14*, 4047. [CrossRef]
36. Jerome, L.; Masood, S.; Henden, J.; Bird, V.; Ougrin, D. Solution-focused approaches for treating self-injurious thoughts and behaviours: A scoping review. *BMC Psychiatry* **2024**, *24*, 646. [CrossRef]
37. Perry, N.; Goldie-McSorley, L. Suspending Disbelief—Using Solution Focused Practice with Young People in Mental Health Crisis. *J. Solut. Focus. Pract.* **2024**, *8*, 1–14. [CrossRef]
38. John, H. *Preventing Suicide: The Solution Focused Approach*; Wiley: Hoboken, NJ, USA, 2017.
39. Perry, N.; Orr, M. *Solution Focused Practice and Mental Health Crisis*; Routledge: London, UK, 2025. [CrossRef]
40. McCabe, R.; Akubat, A.; Bakou, A.E.; Long, M. 'This magical lightbulb went off in my head'—How training NHS staff in Solution Focused Practice can change the experience of people presenting in mental health crisis. In *Solution Focused Practice and Mental Health Crisis*; Routledge: London, UK, 2025; pp. 44–54. [CrossRef]
41. Mughal, F.; Troya, M.I.; Dikomitis, L.; Tierney, S.; Corp, N.; Evans, N.; Townsend, E.; Chew-Graham, C.A. The experiences and needs of supporting individuals of young people who self-harm: A systematic review and thematic synthesis. *eClinicalMedicine* **2022**, *48*, 101437. [CrossRef]

MDPI AG
Grosspeteranlage 5
4052 Basel
Switzerland
Tel.: +41 61 683 77 34

MDPI Books Editorial Office
E-mail: books@mdpi.com
www.mdpi.com/books

Academic Open
Access Publishing

mdpi.com

ISBN 978-3-7258-8038-6