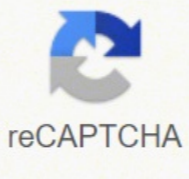




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**Prevalence, Response and Management of Self-harm in School Children Under 13 Years of Age: A Qualitative Study**

Michelle L. Townsend<sup>1,2</sup> · Alkha Jain<sup>1</sup> · Caitlin E. Miller<sup>1,2</sup> · Brin S. F. Greyer<sup>1,2</sup>

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**Abstract**  
 Research suggests that the incidents of self-harm among young people are increasing and age of onset of self-harm is decreasing. There is limited understanding of how widespread the problem of self-harm among younger school students is, and how schools respond to these incidents. This study used an in-depth qualitative approach to understand self-harm in children under 13, and how elementary schools respond including typical actions, support for the child and parental involvement. School psychologists in New South Wales, Australia (n=17, 78% females), completed in-depth interviews detailing types of self-harm, prevalence and frequency, and how these incidents were managed, including student intervention approaches and participation of parents. Thematic analysis of interviews was conducted. Psychologists estimated the prevalence of self-harm in their schools was 6.5% and was increasing, with an average age of onset of 10.8 years. Self-harm was most often understood as a coping mechanism associated with anxiety, stress and being bullied. Six themes emerged from the interviews. School psychologists reported that self-harm occurs less frequently in primary school children than high school children, but noted these behaviours still require early intervention. Participants felt they were limited in the support they can provide students who self-harm, and wanted more training for all school staff and parents in identifying and responding to student self-harm. School psychologists are important in identification and management of self-harm, and they report they need further support in helping children who are engaging in self-harm behaviours. Upskilling teachers and parents may assist in reducing rates of self-harm among children.

**Keywords** Self-harm · Primary school · School psychologist · School counsellor · Children

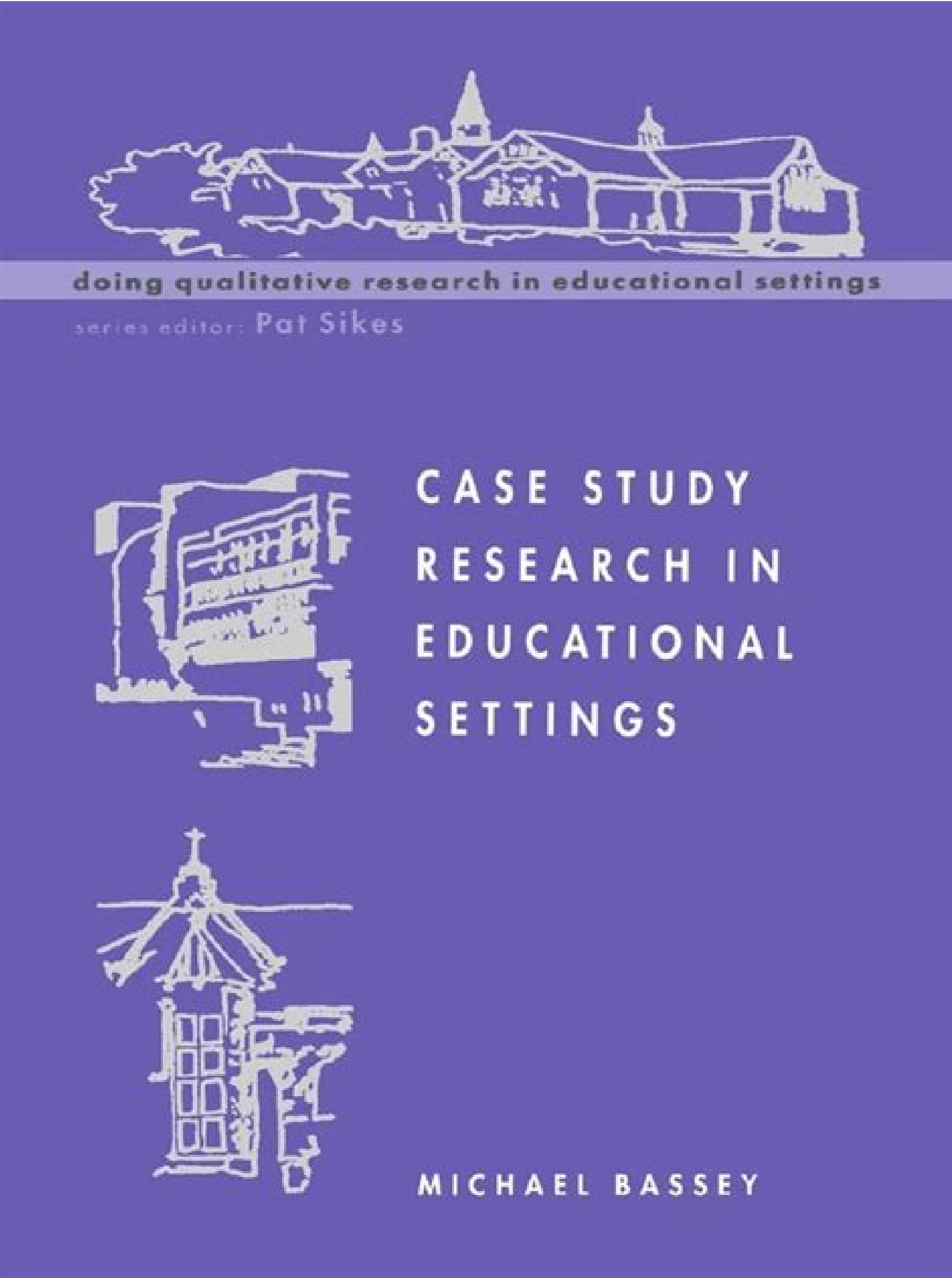
Self-harm among young people is a major public health issue (Hawton, Rogers, et al., 2012; Hawton, Saunders, et al., 2012). Definitions of self-harm vary, but typically include deliberate harm to oneself by methods such as cutting, hitting, burning, scratching or ingestion of legal or illegal drugs (Greyer et al., 2016; Hawton et al., 2012; Hawton, Saunders, et al., 2012). Self-harm is a risk factor for future self-harm, suicidal behaviour and suicide (Hawton, et al., 2012a, 2012b; Madge et al., 2008).

2011; Mitchell et al., 2018; Stigarsky et al., 2013). An American study found that 26% of third graders reported having self-harmed (Barvas et al., 2012). For those who reported self-harm, 60% reported they had hit themselves, and 13.3% reported cutting or carving their skin. Further, a study in Ireland reported that between 2007 and 2016, the age of onset for self-harm in young people decreased, while rates of self-harm increased (Griffin et al., 2018).

Self-harm is increasing in younger populations and has been identified in children as young as six years old (Australian Institute of Health & Welfare, 2014; de Klerk et al., 2015). Methods of self-harm in children may typically be less severe than methods of adolescents and adults, however, they can be an indication of stress and poor emotional regulation, which can often develop into more severe mental health disorders (Bramer et al., 2007; Chapman et al., 2006; De Leo & Heller, 2004). In adolescents, self-harm has been linked to underlying mood and emerging personality disorders (Chapman et al., 2006). It is also associated with low self-esteem (De Leo & Heller, 2004), greater impulsivity (Hawton, Rogers, et al., 2012; Hawton, Saunders, et al., 2012), experiences of sexual or physical abuse (Palmer &

<sup>1</sup> School of Psychology, University of Wollongong, Wollongong, NSW, Australia  
<sup>2</sup> Illawarra Health and Medical Research Institute, University of Wollongong, Wollongong, NSW, Australia

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Open access Original research

**Experiences of pain in paediatric chronic fatigue syndrome/myalgic encephalomyelitis: a single-centre qualitative study**

Teona Serafimova<sup>1</sup> · Caitlin Accough<sup>1</sup> · Roxanne Morin Parslow, Esther Crawley<sup>1</sup>

**ABSTRACT**  
**Background:** Moderate to severe pain affects up to two thirds of children with chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME) and is associated with severe fatigue and physical functioning. This research aims to gain a greater insight into pain experienced by these children.  
**Methods:** Thematic analysis of qualitative data from semi-structured interviews with 13 children with CFS/ME (mean age = 12.3 years; CFS/ME level was confirmed).  
**Results:** Thematic analysis enabled construction of three themes: children's pain-experiencing experience of pain, negative impact of pain and lack of effective treatment for pain and sleep disturbance. The first theme demonstrated highly varied pain experiences, ranging from 'not being' or 'not being noticed to 'hell'. Children reported pain in multiple sites and with wide-ranging frequency and severity. The second theme highlighted the profound negative impact of pain on multiple aspects of children's lives. Physical activity was severely impacted, some children couldn't leave bed or toilet. Sleep wasn't restful. Additional pain meant some would 'go, days without eating'. Pain substantially impacted on mental health, leaving children feeling isolated, experiencing 'why had pain affected me' rather than 'what is treatment'. Children felt they 'can't do the things that everyone else can do', had 'missed out' and are 'behind everyone'. Some avoided socialising as they 'don't want to stop everyone else'. The third theme demonstrates the absence of adequate treatment for pain, with participants reporting 'nothing has ever truly got rid of it and only slightly eased the edge off' and 'other experiencing side effects'.  
**Conclusions:** Pain in paediatric CFS/ME is highly variable, common and often results in severe physical and/or mental health. Effective treatments for pain represent an unmet need.

**BACKGROUND**  
 Chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME) is a common disorder affecting between approximately 0.1% and 0.8% of children and adolescents<sup>1,2</sup> which can be disabling.<sup>3,4</sup> It primarily involves severe fatigue but moderate to severe pain is

**What is known about the subject?**  
 Moderate to severe pain affects nearly 60% of children with chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME). No specific treatments exist for pain in paediatric CFS/ME.

**What this study adds?**  
 Pain is variable, common and results in physical isolation and poor mental health for children with CFS/ME. Effective treatments for pain represent an unmet need.

common affecting over 60% of children with CFS/ME,<sup>5</sup> compared with between 3.0% and 16.0% of healthy children.<sup>6</sup> The pain experienced by children with CFS/ME may have similar underlying neuro-psychological mechanisms to paediatric chronic pain syndrome.<sup>7,8</sup> Chronic pain in paediatric CFS/ME is associated with severe fatigue and poor physical functioning.<sup>9</sup>  
 Pain in paediatric CFS/ME is poorly understood and there are no treatments specifically targeting pain in this population. Only five treatment studies included pain as an outcome measure.<sup>10</sup> In these studies, treatments included CBT (cognitive behaviour therapy, a self-administered method), the Lightning Process and low-dose (clonidine). No interventions resulted in a significant reduction in pain although two studies suggested that pain may improve in those who are 'recovered' compared with 'non-recovered'.<sup>11</sup> Current NICE (National Institute for Health and Care Excellence) guidelines for patients with CFS/ME from 5 years old to adulthood, suggest low-dose amitriptyline, 'relaxation techniques' and consideration of referral to chronic pain services, if appropriate.<sup>12</sup> No

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# What Are the Barriers to Adoption of a Lifestyle Associated with Optimal Peak Bone Mass Acquisition? A Qualitative Study of Young Adults in New Zealand

Sana Zafar <sup>1,†</sup>, Hayley Denison <sup>2</sup>, Hansa Patel <sup>1</sup> and Elaine Dennison <sup>1,3,\*</sup> <sup>1</sup> School of Biological Sciences, Victoria University of Wellington, Kaitiaki, Wellington 6142, New Zealand; sanazafar@vuw.ac.nz (S.Z.); hansa.patel@vuw.ac.nz (H.P.)<sup>2</sup> Centre for Public Health Research, Wellington Campus, Massey University, Wellington 6140, New Zealand; H.Dennison@massey.ac.nz<sup>3</sup> MRC Lifecourse Epidemiology Centre, University of Southampton, Southampton SO9 4DY, UK

\* Correspondence: em.dennison@vuw.ac.nz or elaine.dennison@vuw.ac.nz

**Abstract:** Objective: This study aimed to investigate the barriers to adopting lifestyle factors other than physical activity important for optimal peak bone mass (FBM) acquisition—namely, dietary factors, avoidance of cigarette smoking, and keeping alcohol consumption within recommended limits. Materials and Methods: University students and staff aged 18–30 years were recruited. Six semi-structured, in-depth focus group interviews were conducted with a total of 28 participants. The interviews were digitally recorded and transcribed. A thematic approach for data analysis using a constant comparative method was performed using NVivo software. Results: Three major themes emerged: socio-cultural barriers (peer pressure and cultural norms), personal barriers (time, cost, and diet preferences), and other barriers (medical illness and lack of symptoms associated with low bone mass density). Conclusions: We identified several barriers to adoption of lifestyle behaviours that might be beneficial to FBM acquisition. These data might facilitate the development of public health interventions designed to help young adults embrace osteoprotective lifestyles, and hence reduce the burden of osteoporotic fracture in later life.

**Keywords:** peak bone density; qualitative; young adult

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## 1. Introduction

Osteoporosis is a major public health problem through its association with fragility fracture in later life [1]. According to the Osteoporosis New Zealand (ONZ) annual report published in 2017 [2], more than 1.6 million New Zealanders are currently over the age of 50 years, and more than 180,000 New Zealand adults aged >50 years have sustained a fragility fracture. The same report suggests that every year in New Zealand almost 3700 people sustain a hip fracture, and almost 13,800 are admitted to hospital with other fractures [2]. Since it is estimated that the proportion of the New Zealand population over 50 will increase from 33% in 2015 to 38% in 2035, the prevalence of osteoporosis is set to increase still further [2]. Similarly, around 4.7 million Australians over 50 years of age have been reported to have osteoporosis, osteopenia, or poor bone health [3]. By 2022, it is estimated there will be 6.2 million Australians over the age of 50 with osteoporosis, a 31% increase from 2012 [4].

Fragility fracture carries with it very significant financial as well as personal burden; it was estimated that hip fractures cost the New Zealand Health system NZD 171 million in 2014 and the total costs including fragility fracture at all sites is likely to exceed NZD 300 million per year [2]. Osteoporosis Australia estimated the total costs of fragility fractures to be AUD 2.4 billion (USD 1.7 billion) in 2019, increasing to AUD 2.6 billion (USD 1.8 billion) by 2022 [5].

Examples of assumptions in qualitative research.pdf.

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