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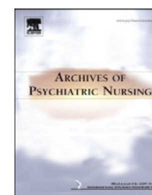

Pushing the Boundaries: Understanding Self-Harm in a Non-Clinical Population

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A B S T R A C T

This study investigates 122 people's descriptions of their self-harm experiences using thematic analysis. Analysis revealed four themes: What counts as self-harm, What leads to self-harm, Intentions and Managing stigma. Our participants challenged commonly accepted understandings in terms of method, outcome and intentions. Several difficulties associated with discriminating between suicidal and non-suicidal self-harm were highlighted, which may be important in clinical practice. Few participants mentioned diagnosed psychiatric disorders; they best understood self-harm through their social experiences. Focusing on social understandings of self-harm may help reduce associated stigma and barriers to help-seeking.
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SELF-HARM IS a public health problem thought to be on the rise (Fortune & Hawton, 2005; Klonsky, 2007). It is considered a predominately female behaviour and more common in young people than in other age groups (Clarke & Whittaker, 1998; Schmidtke, Bille-Brahe, De Leo, & Kerkhof, 2004). In Bærum, Norway, rates of hospital treated deliberate self-harm were estimated to be around 200 per 100,000 for female adolescents and less than 50 per 100,000 for male adolescents in 2006 (Dieserud, Gerhardsen, Van den Weghe, & Corbett, 2010). Self-reported lifetime self-harm in a Norwegian non-clinical adult sample was around 4% (Hjelmeland & Knizek, 2010), although the rate among adolescents is higher (Ystgaard, Reinholdt, Husby, & Mehlum, 2003). As well as by gender and age, rates also vary with the definition of self-harm used. The current study uses thematic analysis to explore how young adults in the general population who have self-harmed describe their experiences.

Experience of self-harm

Qualitative studies considering the experience of self-harm are often based on small scale interviews, while in others, participants write about their experiences. Studies focus predominantly, although not always exclusively, on women, because women are more likely to engage in self-harm than men. Psychological factors associated with self-harm include feeling rejected, feeling depressed or experiencing a lack of control (Everall, 2000). Social factors include family problems, poverty or traumas such as sexual assault or bereavement (Abrams & Gordon, 2003; Harris, 2000; Rissanen, Kylma, & Laukkanen, 2008).

Different intentions have been reported in qualitative studies including relieving or communicating emotional distress or anger, regaining control in life or a wish to die (Abrams & Gordon, 2003; Marshall and Yazdani, 1999; McAndrew & Warne, 2005). Ending dissociation, punishing oneself or avoiding suicidal actions may also be important intentions (Polk & Liss, 2009), while a few may merely be experimenting (Rissanen et al., 2008).

Defining self-harm

In the literature, there is little consensus over the definition of, or the terminology for, self-harm. Self-mutilation (also termed non-suicidal self-injury) is the deliberate destruction of one's own body tissue in the absence of suicidal intent (Favazza, 1998). Attempted suicide on the contrary refers to self-harm where the person has some intent to die, although in many studies this term describes all non-accidental medically treated self-poisoning and self-injury not resulting in death, regardless of the intention (Schmidtke et al., 2004). This has also been referred to as parasuicide (Bille-Brahe et al., 1995) and deliberate self-harm (Fortune & Hawton, 2005). Intentions, suicidal or non-suicidal, are central to the long standing debate in the literature about how to term and categorise self-harm.

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For a summary of the challenges involved in classifying self-harm, see Silverman (2011).

The lack of consistent nomenclature in suicidology makes comparisons across studies problematic. Plus, different samples are used across studies; psychiatric patients, adolescents or somatic patients. Some focus on either suicidal or non-suicidal self-harm. While some researchers and some people who self-harm may emphasise a distinction, self-harm may also be conceptualised on a continuum with varying levels of suicidal intent (O'Carroll et al., 1996). How intention should be defined and where the boundaries lie may be difficult to establish (Silverman, 2011). Some people may engage in both non-suicidal and suicidal self-harm (Spandler, 1996), and many may be ambivalent. Considering non-suicidal self-harm in isolation to suicidal self-harm, or vice-versa may limit our understanding of self-harm. Additionally, the varying definitions are typically made by professionals and rarely consider the experts' perspectives; that is, those who self-harm. If these perspectives differ, then self-harm may often go unrecognised. In this study, like some other qualitative research focussing on participants' experiences, our definition of self-harm is not closed; rather, we seek to prioritise participants' understandings.

The present study

This paper stems from a larger quantitative study relating to self-harm among young Norwegian adults. Participants who indicated having ever intentionally harmed themselves were asked to describe what they had done. These descriptions were used to ask: How do people who have self-harmed describe the experience?

Method

Participants were from a sub-sample of 522 individuals who anonymously completed an online quantitative survey looking at psychological factors relating to self-harm and suicidality. It was aimed at adults living in Norway aged between 18 and 35 years, although a few adults over 35 also responded. The survey was advertised on various popular Norwegian Web sites including online newspapers and social networking Web sites. Those wishing to participate could complete the questionnaire electronically after confirming they were over 18 years old and giving consent for participation. Participants were given advice about whom to contact in the event of distress and could withdraw from participation at any time. Ethical approval to conduct this study was granted by the Norwegian Regional Committee for Medical and Health Research Ethics.

Approximately 28% (144) of respondents answered yes to the following question: ‘Have you ever deliberately taken an overdose (e.g. of pills or other medication) or tried to harm yourself in some other way (such as cut yourself)?’ They were then asked to ‘please give details about what you did’ [questions were derived from Child and Adolescent Self-Harm in Europe studies (CASE) (Ystgaard et al., 2003)]. These open, qualitative descriptions are the focus of the current study.

Of the 144 participants who indicated that they had ever harmed themselves, 22 did not give a description. Analysis is based on the remaining 122 participants. Ninety-six were women (79%), 25 (20%) were men and one did not report his or her gender. Three participants were aged 36–40 and one over 40, but indicated harming themselves when they were younger. The mean age (after excluding these outliers) was 22.62 years (SD = 5.14). The majority of participants were heterosexual ($n = 95$, 78%), single ($n = 89$, 73%) and Norwegian with at least one Norwegian parent ($n = 110$, 90%). Thirty-six participants (30%) reported ever requiring medical treatment as a result of self-harming and 44 (36%) reported self-harming within the last year.

Analysis

An inductive thematic analysis as described by Braun and Clarke (2006) was carried out. The data were thoroughly read before coding units of text into analytical categories based on the patterns observed. More than one category could be assigned per unit of text. Categories were then reviewed for cohesion and to check there was enough data to support it. By continually referring to the text and through discussion between the authors, categories were grouped into higher-order themes by merging sub-categories. Quotes from participants in this paper were translated from Norwegian to English by the first author, a native English speaker who also speaks Norwegian.

Findings

Descriptions ranged in length from one word to half a page, although most (89%) were under 50 words. Method was mentioned by almost all participants ($n = 120$; 98%). The most common were cutting type behaviours (cutting, scratching or poking sharp objects into the skin) (78%), overdose (30%), hitting oneself/things (9%) and hanging (8%). Around 29% of participants had used more than one method and 76% had self-harmed on more than one occasion.

The four key themes arising from respondents' descriptions about their self-harming experiences were: what counts as self-harm, what leads to self-harm, intentions, and managing stigma. These themes represent two different levels of analysis. The first three offer an analysis at the level of events, actions, and understandings. We may understand these themes to work at the psycho-social level. The fourth theme offers analysis at the socio-cultural level. The focus here is on participants' reports of self-harm while considering the socio-cultural context within which it takes place.

What Counts As Self-Harm?

In the descriptions, a number of participants explicitly used the term self-harming. Some simply wrote “self-harming” without elaborating, suggesting this term has a shared meaning. It seemed clear from other participants that the cultural understanding of self-harming was equated with cutting-like behaviour; “self-harming such as cutting and stabbing” (woman), “self-harming with sharp objects” (woman). Such behaviour is not usually associated with high lethality or suicidal intent and is often referred to as non-suicidal self-injury (Laye-Gindhu & Schonert-Reichl, 2005). Consistent with this, participants did not use the term self-harm in relation to methods associated with higher lethality. In fact, they seemed to distinguish between self-harming (as a cutting-like behaviour) and other methods: “Several overdoses with pills. Quite a bit of self-harming (cutting). Tried to strangle myself …” (woman).

The descriptions suggested that participants who had cut themselves mostly targeted their wrists or forearms, although upper arms, legs and stomach were also mentioned. In line with descriptions of self-cutting among Finnish adolescents (Rissanen et al., 2008), a range of different tools were used by our participants; with the most common being knives and razors. For some participants, the cutting only took place once or twice, while others had engaged in it more frequently and over a long period, as suggested by the extract below:

> I struggled with self-harming from when I was in fifth grade until the senior years at high school. Since then it has been more sporadic. I try to stay away from it…But it was everything from cutting with knives, shards of glass, scissors and scalpels to scratching with my nails or sandpaper until I bled (woman).

A range of other methods were also mentioned by participants, some of which may not be accepted under ‘typical’ definitions of self-harm. For instance, the same woman quoted above added “I've not

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