

# Understanding resolution of deliberate self harm: qualitative interview study of patients' experiences

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## Abstract

**Objective** To explore the accounts of those with a history of deliberate self harm but who no longer do so, to understand how they perceive this resolution and to identify potential implications for provision of health services.

**Design** Qualitative in-depth interview study.

**Setting** Interviews in a community setting.

**Participants** 20 participants selected from a representative cohort identified in 1997 after an episode of deliberate self poisoning that resulted in hospital treatment. Participants were included if they had no further episodes for at least two years before interview.

**Results** We identified three recurrent themes: the resolution of adolescent distress; the recognition of the role of alcohol as a precipitating and maintaining factor in self harm; and the understanding of deliberate self harm as a symptom of untreated or unrecognised illness.

**Conclusion** Patients with a history of deliberate self harm who no longer harm themselves talk about their experiences in terms of lack of control over their lives, either through alcohol dependence, untreated depression, or, in adolescents, uncertainty within their family relationships. Hospital management of deliberate self harm has a role in the identification and treatment of depression and alcohol misuse, although in adolescents such interventions may be less appropriate.

## Introduction

The National Institute for Clinical Excellence (NICE) has published guidelines on the short term management of patients who self harm,<sup>1</sup> noting the limited evidence on effective interventions and recommending qualitative research to explore patients' experiences of services and understanding of deliberate self harm. The few published qualitative studies have concurred that deliberate self harm is an externalised way of representing diffuse intrinsic distress.<sup>2-5</sup> To date, qualitative research has not examined long term outcomes. This is especially salient because of the limited efficacy of secondary prevention interventions; patients' accounts of deliberate self harm and the treatment received may help inform the development and implementation of more effective management strategies.

We examined how those who had previously presented to hospital after an episode of deliberate self poisoning but who had not harmed themselves in the past two years, discussed their self harming behaviour and the health services they received at the time. We explored these accounts to identify how patients accounted for this resolution.

We analysed patients' accounts in terms of what we could learn about their experiences from the stories they tell. One perspective that aided this approach was

Arthur Frank's discussion of illness stories as a way of "giving voice to the body."<sup>6</sup> Frank defines three types of illness narrative: those of restitution, which tell of the body restored to health; those of quest, which construct illness as a journey; and those of chaos, which remain unresolved. Subjective tales are also important in that they allow a re-evaluation of the past, enabling the story teller to make sense of the present and future.<sup>7</sup>

## Methods

This qualitative in-depth interview study was part of a larger follow-up study of 150 patients recruited to a multicentre study on parasuicide in 1997. We purposively selected 20 participants (from a sample who had not harmed themselves in the past two years) to reflect the sex and history of deliberate self harm of patients in the original cohort (see [bmj.com](http://bmj.com)).

The interviewer had no clinical responsibility for the participants involved. We used a relatively open interview schedule, inviting patients to talk about their lives now and in 1997 and to highlight important events in the intervening period. All topics were covered in each interview, which lasted between 45 minutes and an hour. Interviews were taped, corrected, and analysed aided by computer software. Analysis was both thematic and narrative. Thematic analysis used some of the principles of grounded theory. Narrative analysis entailed in-depth reading of transcripts to characterise the stories by Frank's model of illness narratives.<sup>6</sup>

## Results

JS interviewed 12 women and eight men (table). Three key narratives of resolution emerged that typified most (18/20) of the participants. The two other participants described a single episode of deliberate self harm in the context of overwhelming acute life difficulties.

### Resolution of adolescent chaos

For nine participants, still dependent on their parents in 1997, the defining difference between "now" and the time of their deliberate self harm was the resolution of their lack of control within the family structure. Most talked of the unpredictability of family life in 1997, ranging from specific accounts of sexual abuse or physical violence to more general memories of confusion or feeling unsupported (box 1). Family life was recounted as not just chaotic but also failing to provide any validation of their experiences at the time: interviewees recalled feeling that they were "not heard" (six participants) or that their story was considered unimportant: "I told my mum that my dad had abused



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**Box 1: Unpredictability of family life**

I mean we had the slipper and we had the belt and when we did get a smack it was a smack, and occasionally you know I'd be on the brunt of someone losing their rag and I'd get a, I wouldn't call it a beating ... just a good hiding, which I still, I think was too much (participant 2, female, aged 20 in 1997)

My mother used to go through my letters ... she read the letters and interpreted them the wrong way ... she made me sit in front of her and rip them, these letters, I had to rip them. She ruled that house, and the only way sometimes to get yourself heard was to do that [self harm] (participant 6, male, aged 21 in 1997)

[Dad] had been drinking ... I don't think he meant to hurt me, he just walked past and kicked me right in the hip but Tom [little brother] went and reported it so we got put on the child protection list. I think it's the child protection list. We were on there until I was 16 (participant 5, female, aged 16 in 1997)

They had a lot of plans laid out for me and I had to get certain grades so when I didn't they weren't very happy at all ... My mother, she's an alcoholic and at that age I didn't understand a lot of what she said and what she did, it wasn't actually her fault but I just took it personally (participant 7, female)

me and she didn't believe me. And she apparently told my brother what I had said and my brother didn't believe me either and they just both wanted to carry on" (participant 1, female, age 19 in 1997).

Within this context participants told of overwhelming feelings of isolation and despair. Although recalling events of up to seven years ago, several became tearful when talking of their feelings. In Frank's types of illness stories, the parts of the interview where these participants recalled their adolescence were typically "chaos" narratives, full of pauses and dislocations.

While three people in this group described a wish to die at that time, others acknowledged that the key motivation was for someone to hear and validate their distress. No participants from this group said that help offered as part of the hospital assessment was beneficial. Instead, admission to hospital was remembered as a frightening experience which furthered their perception of lack of control: "I remember thinking 'I'm not like them, you're not putting me in there [deliberate self harm ward]'. And then them putting me in this bay in this awful, awful ward where there were just a real variety, I guess it was a bit like a pick and mix bag and it was just, it was awful, it was absolutely awful and I think I was probably quite young by comparison

with the majority of the people there and it was yeah it was a horrible, horrible experience" (participant 3).

Several participants talked of difficulty in engaging with a potentially helpful but new relationship offered during assessment, either seeing it as a requirement they had to agree to, to be allowed home, or as not matching their needs at that time: "So I went to see this counsellor and she just took me through this cognitive whatever [therapy], she spent an hour going through all this rubbish, and I just wanted to talk and she just wanted to go through her theories" (participant 6).

Three participants mentioned helpful existing relationships with professionals such as general practitioners or school counsellors: "He [general practitioner] was like rock. He really was, he was genuinely concerned for me and I could tell he was. He was really worried and in a way he made me feel better you know that someone cared and he, he would see me every, maybe every month every two months just to see how everything was and till he retired really so he was a great help" (participant 8).

The narrative style shifts when these participants describe their lives now, in which a sense of autonomy is the key change identified. In Frank's classification, these stories now are essentially "quest narratives," in which they describe successfully breaking away from their family and achieving independence as adults. While this involves (often onerous) responsibilities, it also provides separation from reliance on what were typically unpredictable family environments. Participants describe their lives now as having a sense of purpose, allowing them enough control to manage their responses to distress in a less self destructive way: "I'm responsible for [the baby] you know. I've stopped being so selfish about myself, worrying about my hang-ups and stuff. I've got someone else to think about, I've got a reason for getting up out of bed in the morning ... ." (participant 2).

**Recognition of alcohol as a factor**

The second recurring story, which dominated for four participants, was that of recognising alcohol as a factor in deliberate self harm. All were abstinent when interviewed, and had a history of considerable alcohol misuse in 1997 (box 2). Looking back, they attributed their use of alcohol to an attempt to escape from difficult emotions but now saw it as precipitating a vicious cycle of low self esteem and self loathing: "I used to just get stressed out and think 'right hit the bottle.' Of course I'd hit the bottle, get all depressed, at first I'd feel a bit better, more relaxed ... then I'd end up being like a

Characteristics of three "narrative" groups at index episode

Characteristic	Adolescent	Illness	Alcohol	Other
No in group	9	5	4	2
Only episode of DSH	2	2	0	2
Mean (range) years since last episode	3.9 (3.3-7.0)	6.3 (5.3-7.5)	5.2 (3.5-6.6)	6.7 (6.5-6.9)
Diagnosis at index episode	Harmful use of alcohol (1), none (2), depression (6)	Depression (4), OCD (1)	Harmful use of alcohol (1), alcohol dependence (3)	None (1), somatoform pain disorder (1)
Mean (range) index SIS	10 (5-20)	13 (3-24)	8 (3-12)	18 (13-23)
Employment status at index episode	Full time education (4), unemployed (1), sick (1), employed (3)	Employed (4), disabled (1)	Unemployed (3), housewife (1)	Employed (1), disabled (1)
Mean (range) age at index episode (years)	19.2 (16-25)	39.6 (33-48)	38.8 (24-48)	41 (34-48)

DSH=deliberate self harm; OCD=obsessive compulsive disorder; SIS=suicide intent scale (increased score suggests higher risk of suicide).

volcano where I'd explode and I'd either go and hit out at somebody or hit back on myself because I can't cope with this and that's when I'd hit myself hard" (participant 9, female).

All four of these participants clearly relate that admission to hospital after deliberate self harm acted as only a temporary respite from their difficulties; the process and practicalities of stopping drinking, which were key in affecting their behaviour, were either not sought or unavailable: "No, the self harm was a cry for help, it wasn't an attempt to kill myself. It was actually the alcohol that was killing me. I just used another drug because at the end of the day if you ring up a hospital and say you're drunk they tell you to bugger off, if you ring up and say you've swallowed a bottle of pills, they let you in" (participant 12).

The effect of abstinence was framed within a restitution narrative, in that abstaining was, in these stories,

### Box 2: Alcohol narrative themes

#### Experiences of hospital care

I think there was an alcoholic team but to be quite honest with you it was pretty nondescript, what I know about the illness now, pretty nondescript. And I suppose I wasn't educated enough to my belief that I realised that alcohol was so damaging with a low mood (participant 10, female)

#### Decisions to change

I do remember, this is six years ago, I remember just waking up and feeling this can't go on; I cannot go on living this life of lying in bed and drinking . . . if I start drinking I might as well be dead because the life that it gave me, because when I drink I choose not to function (participant 10)

The fact that I don't drink any more basically allows me a life. Drink effectively removed the ability to function as a normal human being (participant 12)

### Box 3: Illness narrative themes

#### Feelings at time of deliberate self harm

It had in no way occurred to me that I might be ill. I hadn't even thought about depression being involved, never crossed my mind . . . I didn't see avenues. Going to the doctor didn't even enter my head (participant 14, male)

I felt useless I suppose, I felt I couldn't care for the children, that they were better off without me, I sincerely thought that . . . (patient 15, female)

#### Avenues of support

About three years, two or three years [in group therapy] and I've suddenly been put in touch with . . . the wounded side of myself with painful memories and I find that my delusions about people I have in the outside world have transferred to members of the group so everything's reproduced there so that's quite helpful really (participant 12)

If I felt any differently I would certainly get me to the doctors and say, "look you know I'm still taking these [antidepressants] but x, y, or z is, or is not happening, should we be investigating this?" and I would be doing that with total confidence that my doctor would . . . (participant 14)

### What is already known on this topic

Rates of deliberate self harm continue to rise within the UK

There is limited evidence for the efficacy of most available treatments

### What this study adds

Patients with a history of deliberate self harm (who no longer harm themselves) talk about their experiences in terms of lack of control over their lives, either through alcohol dependence, untreated depression, or, in adolescents, uncertainty within their family relationships

Hospital management of deliberate self harm has a role in the identification and treatment of depression and alcohol misuse, although in adolescents such interventions may be less appropriate

the route to regained self pride and individuality and an immediate end to their acts of self harm that required hospital admission.

### Seeing deliberate self harm as a consequence of illness

For this group of participants, their overdose was narratively constructed as the "trigger" for getting help. In contrast with the narratives of participants in the adolescent group, hospital services were seen as a positive factor in the resolution of self harm. All described significant depressive symptoms at the time, culminating in the index attempt in 1997, including descriptions of isolation and desperation (box 3). In retrospect, they understood that deliberate self harm could be seen as a symptom of illness, but at the time they were faced with feelings of hopelessness that seemed insoluble.

Admission to hospital was seen as part of the process of recovery, with the recognition of their suicidal behaviour as being a symptom of depression, which was seen as manageable by their own efforts with support from professional services. They all saw the potential to be in the same position again, but by constructing their experiences within a restitution type narrative of illness, they have identified legitimate avenues of support that were not previously open to them.

### Discussion

The narratives people construct to make sense of their experiences offer an alternative perspective for researchers and policy makers to consider when planning services and future intervention studies. This study was limited by its small sample size, drawn from those in a cohort of patients who no longer harm themselves, and we do not know how far our findings can be generalised to those with ongoing episodes of deliberate self harm.

Rates of deliberate self harm in adolescents are continuing to rise.<sup>8</sup> Our study suggests that secondary services have limited impact in young people, who reported difficulties engaging with unfamiliar staff (as

opposed to trusted and known general practitioners and counsellors) as part of what was perceived as a traumatic hospital admission. These results also indicate the imperative for finding solutions outside the emergency department, in primary care or education systems.

Secondly, it is important that several participants identified abstaining from alcohol as key to the resolution of deliberate self harm. Given the correlation between alcohol dependence and the risk of suicidal behaviours, as well as the potential for brief interventions in emergency departments,<sup>9</sup> this may be an area for further research, particularly as some participants considered deliberate self harm as a way of accessing services.

Finally, the recognition and treatment of depression, especially in men, in primary care remains important in the prevention of suicidal behaviour, as is the greater challenge of public education campaigns to improve public (and professional) understanding of mental illness and the effective treatments available.

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## Longitudinal study of birth weight and adult body mass index in predicting risk of coronary heart disease and stroke in women

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### Abstract

**Objectives** To determine whether birth weight and adult body size interact to predict coronary heart disease in women, as has been observed for men. To determine whether birth weight and adult body size interact to predict risk of stroke.

**Design** Longitudinal cohort study.

**Setting and participants** 66 111 female nurses followed since 1976 who were born of singleton, term pregnancies and reported their birth weight in 1992.

**Main outcome measures** 1504 events of coronary heart disease (myocardial infarction or sudden cardiac death) and 1164 strokes.

**Results** For each kilogram of higher birth weight, age adjusted hazard ratios from prospective analysis were 0.77 (95% confidence interval 0.69 to 0.87) for coronary heart disease and 0.89 (0.78 to 1.01) for total stroke. In combined prospective and retrospective analysis, hazard ratios were 0.84 (0.76 to 0.93) for total stroke, 0.83 (0.71 to 0.96) for ischaemic stroke, and 0.86 (0.66 to 1.11) for haemorrhagic stroke. Exclusion of macrosomic infants (>4536 g) yielded stronger estimates. Risk of coronary heart disease was especially high for women who crossed from a low centile of weight at birth to a high centile of body mass index in adulthood. The association of lower birth weight with

increased risk of stroke was apparent across categories of body mass index in adults and was not especially strong among heavier women.

**Conclusions** Higher body mass index in adulthood is an especially strong risk factor for coronary heart disease among women who were small at birth. In this large cohort of women, size at birth and adiposity in adulthood interacted to predict events of coronary heart disease but not stroke events.

### Introduction

New data continue to fuel the debate surrounding the "fetal origins hypothesis" that prenatal environment affects the risk of adult cardiovascular disease. Taken as a group, the published cohort studies have found a roughly 20% lower risk of cardiovascular disease for every kilogram of higher birth weight.<sup>1</sup>

Stratification by adult body mass index (BMI, kg/m<sup>2</sup>) has indicated that birth weight and BMI may interact to predict risk of coronary heart disease. Several,<sup>2-4</sup> but not all,<sup>5</sup> studies among men have reported an especially high risk of coronary heart disease among men who

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