Papers

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

Deliberate self harm is a major public health problem. Services for patients vary widely across the country, and there is little convincing evidence for the efficacy of most treatments.1 In July 2004 the National Institute for Clinical Excellence (NICE) published guidelines on the short term management of patients who self harm,2 noting the limited evidence on effective interventions and recommending research with appropriate qualitative methods to explore patients’ experiences of services and understanding of deliberate self harm. The few qualitative studies that have been conducted have used different methods but have concurred that deliberate self harm is an externalised way of representing diffuse intrinsic distress.3,4 These studies were all conducted in the period immediately after an episode of deliberate self harm; to date, qualitative research has not examined long term outcomes.

The lack of qualitative research on longer term perspectives, particularly for those who no longer harm themselves, is especially salient because of the limited efficacy of secondary prevention interventions.5 Not only are patients’ accounts of deliberate self harm and the treatment received important in terms of evaluating patients’ perspectives on care, they may also help to 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 (19 after an overdose, one with carbon monoxide 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.

In studying “accounts” of past experiences, we were not necessarily interested in identifying empirically valid reconstructions (that is, checking the details with the medical notes) of precipitating factors, encounters with health services, or factors leading to resolution. Instead, we explored how participants perceived the move away from deliberate self harm and what insights this could provide about the appropriateness of treatment options. We therefore analysed patients’ stories in terms of what we could learn about the experiences of those who have self harmed from the stories they tell. One perspective that aided this approach was Arthur Frank’s discussion of stories about illness as a way of “giving voice to the body.”5 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 escape “narrative closure”—that is, 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.6

Methods

This qualitative in-depth interview study was part of a larger follow-up study of 150 patients. The original cohort was a representative sample of patients presenting to one UK hospital who had harmed themselves7–11 and were recruited as part of a multicentre study on parasuicide in 1997.12 Of this original cohort, 90 agreed to follow-up and were still alive and contactable after seven years. Of these, 31 had not harmed themselves in the past two years, still lived in England, and were willing to participate in an in-depth interview. We purposively selected 20 participants to reflect the sex and history of deliberate self harm of patients in the original cohort (table 1).13

A psychiatrist who was involved in the larger cohort study but had no clinical responsibility interviewed participants. To offset the potential framing of interviewees’ accounts through a professional framework (that is, telling a doctor what they think a doctor will want to hear), participants chose the interview settings, usually their own home. We also used a relatively open interview schedule (box 1), 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 with permission, and corrected transcripts were imported into QSR NVivo software (QSR International, Melbourne, Vic.). Analysis was both thematic and narrative. Thematic analysis used some of the principles of grounded theory\textsuperscript{14,15} such as open coding of early data and working with peer review groups of qualitative researchers, who discussed both the emerging coding scheme and coding decisions to ensure potential avenues of analysis were explored. All data were entered and coded, aiding a thorough and comprehensive analysis, and recurrent themes then identified across the dataset.\textsuperscript{16} Narrative analysis entailed an in-depth reading of transcripts to characterise the structures of the stories by Frank’s model of illness narratives.\textsuperscript{9}

**Results**

JS interviewed 12 women and eight men, 14 of whom had harmed themselves on more than one occasion. To preserve the anonymity of the participants we have not detailed individual characteristics but have summarised them as a group in Table 2. We have focused on three key narratives of resolution that emerged from the analysis and 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.

**Box 1 Interview topic guide**

- Can you tell me a little bit about how things are for you at the moment? (take me through a typical day or typical week?)
- Going back to 1997, tell me how things were at that time? (can you remember what led up to your being in hospital?)
- In what way do you think things have changed (or stayed the same) since that time? (take me through what has happened in the past seven years?)
- What kind of situation in the future do you think might result in your harming yourself again? (if you can’t envisage one, why not?) (Otherwise explore avenues of support/danger)

**Table 2** Characteristics of three "narrative" groups at index episode

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

DSH=deliberate self harm; OCD=obsessive compulsive disorder; SIS=suicide intent scale\textsuperscript{17}; increased score suggests higher risk of suicide.
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: for example, “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, you know, 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, the stories about “life 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. I’ve got a reason for living now since I’ve got a purpose to my life, I want to give my boy the best life that I can” (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 four, who were abstinent when interviewed, had a history of considerable alcohol misuse in 1997 (box 3). 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 and then 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 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 res-
pite from their difficulties; the process and practicalities of stopping drinking, which were key in affecting their self harm 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, the route to regained self pride and individuality and an immediate end to their acts of self harm that required hospital admission: “I feel like I've grown up a lot and I can actually think for myself because I’m not drinking, and I don’t know why I didn’t do it years ago, I just thought [alcohol] was a good solution …” (participant 11).

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 4). 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: “I remember going to see a GP and saying and explaining how bad things had got and how desperate I had become and I really didn’t think I was getting through to him at all. I didn’t think they were taking me at all seriously” (participant 13, male).

What differs in the narratives of this group is that admission to hospital was seen as part of the process of recovery, with the recognition of 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 themselves, and we do not know how far our findings can be generalised to those with ongoing episodes of deliberate self harm. 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. The perspectives explored here, however, offer some tenable generalisation to those with ongoing episodes of deliberate self harm themselves, and we do not know how far our findings can be generalised to those with ongoing episodes of deliberate self harm. The effect of abstinence was framed within a restitution narrative, in that abstaining was, in these stories, the route to regained self pride and individuality and an immediate end to their acts of self harm that required hospital admission: “I feel like I've grown up a lot and I can actually think for myself because I’m not drinking, and I don’t know why I didn’t do it years ago, I just thought [alcohol] was a good solution …” (participant 11).

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Box 4 Illness narrative themes

Feelings at time of deliberate self harm

It wasn’t a rational process with rational or even irrational thoughts going through my mind, it was just a physical reflex action, a craving for comfort I suppose, like an addiction, a physical addiction. I can’t actually put specific psychological thoughts to it apart from the craving for comfort. And possibly the feeling of complete despair (participant 12)

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 . . . although I loved the children desperately, I thought they would be better off, really genuinely, because life was so stressful for everybody, for my husband (patient 15, female)

Avenues of support

My doctor said that I will be taking it [medication] for the rest of my life which I’ve sort of come to accept really, the same as if I was a diabetic or whatever that would be, I’d have to take some form of medication for that and I’ve just come to the conclusion that some people are born with certain chemical defects in their brain or whatever and I’m one of those people and I come from a line of those people, my parents, so it’s through no particular fault of my own (participant 15).

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)

I suppose I know [taking an overdose] is just going to make things worse not better and I think I don’t let things get to that stage any more, if I feel that I really can’t cope with things you know I will go off, I will take the dog for a walk, or even just spend a whole day away and just switch off from it really, and I don’t feel guilty about doing that (participant 16, female)

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)
suggest diverse populations with diverse service needs, many of which are currently inadequately dealt with within the health service.

Contributors: JS carried out the interviews, analysed the transcripts, and discussed the emerging coding schemes and decisions with JG. JS is guarantor.

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Ethics approval: Oxford Psychiatric Research ethics committee and the London School of Hygiene and Tropical Medicine ethics committee.


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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 treatments available

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


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