Chapter 1: Introduction

Those who have made a deliberate attempt to harm themselves are the subjects of this thesis. In this study the life histories of 90 people who have made a deliberate self harm attempt and have come to the attention of the Accident and Emergency Department of Westmead Hospital, Sydney, Australia are explored in detail in order to translate these individual social biographies into a more general understanding of deliberate self-harm.

Deliberate self harming behaviours and attempted suicide have been a subject of concern for many years and are currently considered to be major public health issues (Hawton and Van Heeringen, 2000a). Exact figures on attempted suicide/deliberate self harm are difficult to obtain as epidemiological research into this behaviour has only recently used standardized procedures (Kerkhof, 2000). In addition a large number of the deliberate self harm attempt will not require medical attention. It has been estimated that only 5% to 30% of suicide attempts result in admission to hospital (Serafino et al, 2000). In Australia there were a total of 25,120 episodes of hospital care for deliberate self harm attempts during the financial year 1997/1998 (Steenkamp and Harrison, 2000). Based on these figures in Australia in one year between 84,000 and 500,000 people have made a deliberate self harm attempt.

There is considerable debate within the literature on the link between suicide, attempted suicide and deliberate self harming behaviour. Among those who have successfully completed suicide, 30% to 50% have made prior attempts (Tobin et al, 2001). Suicide and attempted suicide all share intentional or deliberate self harming characteristics but differ with regard to the outcome, that is, whether or not they result in death (Hawton and van Heeringen, 2000a) and some attempted suicides may be conceived as failed suicides. However it is important to note that differences have been found between those who attempt and those who die by suicide. Compared to those who attempt to harm themselves, people who die by suicide are more likely to be male, older, unemployed, to have made previous suicide attempts, to abuse substance abuse and to have had psychiatric admissions (Beautrais, 2001). These differences suggest that the two are distinct, albeit overlapping, groups. The focus of this thesis is on people who have survived a deliberate self harm attempt and whilst
acknowledging the link between the two behaviours will therefore only focus on this group.

**Terminology**

**Deliberate self harm and attempted suicide**

Different terms have been used in the literature to describe the above behaviour. These terms include attempted suicide and deliberate self harming behaviour. The term ‘attempted suicide’ is more generally used in the literature and is used as an umbrella term which covers people who have in common that they inflict acute harm on themselves, poison or injure themselves, or try to do so, with non fatal outcome and that these behaviours occur in conditions of emotional turmoil. These attempts are undertaken with the view to, and expectation of acute self harm or unconsciousness as a means of realising change through the actual or intended consequences (Kerkhof, 2000). The use of the term ‘attempted suicide’ has been criticised because of the fact that a vast majority of suicide attempts were not characterised by suicidal intent (i.e the wish to die). Kerkhof (2000) notes:

> Some attempts are aimed at dying, many are aimed at mobilising help, and other are ambiguously aimed to a certain extent at both. Some attempters are well-prepared, others are carried out impulsively. Attempts may result in very different physical consequences, depending on intention, preparation, knowledge of the lethality of the chosen method and purely coincidental factors. (Kerkhof, 2000 p. 50)

For these reasons other authors prefer the term deliberate self harm to describe the behaviour (Groholt, 1998). Generally, however, in the literature the terms attempted suicide and deliberate self harming behaviour are used interchangeably and describe similar behaviours.

This study gave primacy to the notion of ‘intention to harm oneself’ over ‘intention to kill one-self,’ and people who defined their attempt as being deliberate were included into the sample, regardless of the lethality of the method utilised and/or if the intention was ‘to die’. For these reasons the term ‘deliberate self harm’ was preferred over ‘attempted suicide’. However, as is the case in the literature, these terms will be used synonymously.

**Intention and motive**

Intention and motive(s) of the attempt are important concepts when attempting to define deliberate self harm. In this thesis the term suicidal intent is defined as ‘the
wish to die’ and term motive(s) is used to describe ‘a broad range of inner feelings or perceptions of what the act will lead to’ (Groholt, 1999, p.15).

**Risk factor**

In the literature the term risk factor is frequently and inconsistently used (Groholt, 1999). In this thesis the terms risk factor is defined to indicate a ‘non-random association between characteristics and the outcome, with the added requirement that the factors precede the outcome’ (Groholt, 1999, p. 15).

**Study aims**

There is a vast body of literature available on suicidal/deliberate self harming behaviour. Different risk factors have been found to be associated with the behaviour and a deliberate self harm attempt is more likely to occur in the presence of these risk factors; However no one risk factor in itself can accurately predict such an attempt (Goldney, 1998b). It is the interplay between different variables that is important, rather than any individual risk factors (Beautrais, 1996). There are risk factors that have been found to increase and decrease the patient’s risk of suicide. While a person’s risk of suicide increases with the number of risk factors, these may also act in a synergistic fashion. For example the combined risk associated with risk factors such as co-morbid depression and physical illness may be greater than the sum of the risk associated in isolation (Jacobs et al, 2003).

This research project was developed to gain an understanding of the interrelationship between the social, psychological factors, social stressors and their link to different motives described by the research participants. The aim of this study is to gain a holistic picture of the experiences and circumstances of people who engage in self harming behaviour and the motives they give for the behaviour.

In this study, 90 people who came to the attention of the Accident and Emergency Department of Westmead Hospital, Sydney, Australia and who defined their attempt as deliberate self harm were interviewed as soon as possible after the event. The interviews explored family and personal history, relationships with family, friends and workmates, the events leading up to hospital admission, psychiatric history (including drug and alcohol use) and a mental health assessment by psychiatric staff.

Specifically, this study had the following aims:

1. To investigate the presence of risk factors known to be associated with deliberate self harming behaviour;
2. To determine the stated motives for deliberate self harming behaviour of people who have come to the attention of the Accident and Emergency Department of Westmead Hospital after an attempt to harm themselves; and

3. To investigate the relationship between various risk factors and the reason people give for self harm.

The overall aim of this study was to gain an in-depth understanding of deliberate self harm, taking into account risk factors and stated motives for attempt. Interviewing people who have attempted to harm themselves can give valuable insight on the psychosocial profile, mental state, life events, experiences and coping mechanisms of people who have engaged in deliberate self harming behaviour and can be helpful in the design of therapeutic interventions for this group. Ultimately it is hoped that the results of this study, when brought to the attention of policy makers and practitioners, will influence their policy and practices to the benefit of people who have made a deliberate self harm attempt or may be at risk of doing so, and those people associated with them.
Outline of the thesis:

The next chapter of this thesis lays the necessary foundations for this research. It provides a summary of the current knowledge on deliberate self harming behaviour. The chapter will provide an overview of the extent of the problem and will describe the risk factors that have been associated with suicidal behaviour. This chapter highlights that the mere presence or absence of one or more of these risk factor does not necessarily predict a deliberate self harm attempt and that the diversity of the different risk factors associated with deliberate self harm highlights the complexity of the phenomenon. The last section of this chapter will focus on different subgroups of people who attempt to harm themselves.

Chapter 3 describes the methodology and analysis undertaken for this study. This chapter argues that in order to gain an understanding of the impact of the different factors that influence a decision to self harm, it is imperative to talk to people who have attempted to harm themselves. Interviewing people who have made an attempt to harm themselves is not without ethical difficulties, some of which are discussed in detail in this chapter. This chapter provides a full description of the interview guide and technique utilised in this study as well as the difficulties associated with interviewing people who have made an attempt to harm themselves. The data collected in this study is analysed quantitatively as well as qualitatively and this chapter also provides a description of the different analyses undertaken.

Chapters 4 to 7 will report on the results of this study. Chapter 4 focuses on the quantitative analysis of risk factors that are identified in this study and provides an overview of the characteristics and risk factors of all of the research participants included in the study. This chapter also divides the participants into the Chronic and Acute groups.

Chapter 5 reports on the qualitative analysis of the motive. The first part of this chapter reports on the different motives described. In this section it is argued that people who attempt to harm themselves do so to escape an unbearable mental pain. The second part of this chapter describes the different situations participants described wanting to escape.

Chapter 6 and 7 will report describe in detail the characteristics of the identified subgroups. Chapter 6 focuses on the characteristics of people in the acute groups whereas Chapter 7 describes the characteristics of the chronic groups.
Chapters 8 will discuss the main study findings with respect to the study aims and the literature. This chapter also draws attention to implications for prevention of deliberate self harming behaviour.

The conclusions, Chapter 9 will revisit the important findings of this study.
Chapter 2: Current understanding of deliberate self harm

This chapter will provide a brief exploration of the current understanding of deliberate self harming behaviour. The questions addressed in this chapter are:

- What is the prevalence of deliberate self harming behaviour?
- What are the main theoretical understandings for deliberate self harm?
- What are the risk factors associated with deliberate self harm and how do these interrelate?
- What is known about the motives for deliberate self harm?
- Are there subgroups of people who deliberately harm themselves?

The electronic databases MEDLINE, PSYCHLIT, PsycINFO, EMBASE, APAIS, ERIC, CINAHL, preMEDLINE and the Cochrane Library were searched. As discussed in the introduction the terms attempted suicide, parasuicide and deliberate self harming behaviour have been used interchangeable in the literature to describe similar behaviours (Groholt, 1999). For these reasons the search retrieved English-language articles containing the following elements:

- Deliberate self harm
- Attempted suicide(s)
- Suicidal,
- Self harm(ing)
- Parasuicide
- Self-injury

These combined with terms such as:

- Risk factor(s) – this search included individual risk factors such as age, gender, mental illness, drug and alcohol.
- Social stressors, social factors sociological explanations
- Psychological factors
- Biological factors
• Meaning, motive, intent, wish to die
• Cluster(s), (sub)group(s)

Potential relevant references were retrieved and their reference lists scanned for further possible articles. Government reports, relevant books and book chapters were also reviewed. Studies which had a particular focus on deliberate self harm were favoured. Quantitative and qualitative studies were included into this review. The studies retrieved were appraised in regards to the study design, sample and data collection and for quantitative studies the measures used to analyse the data.

This chapter provides a summary of the literature retrieved. It provides: 1) brief overview of the epidemiology of deliberate self harm; 2) detailed description of the identified risk factors; and, 3) description of the characteristics of subgroups of people who have attempted to harm themselves.

**Trends in deliberate self harming behaviour**

In the introduction it was noted that in Australia whilst substantial data exists for completed suicide. It was also noted that it has been estimated that only 5% to 30% of suicide attempts result in admission to hospital (Serafino et al, 2000). Surveys in which individuals are asked about their suicidal behaviour suggest that between five and ten percent of young people from early teens to twenties report making a suicide attempt in one year (Zubrick et al, 1997). Based on these figures in Australia in the year 1998 between 84 000 and 500 000 people have made a deliberate self harm attempt.

**Age**

The true age structure of those who deliberately self harm is difficult to know as many are unreported. In this section the age structure of people who attempt to harm themselves and have come to the attention of the emergency department will be used as a proxy measure. In general attempted suicide is more frequent among the younger age groups (Moscicki, 1997). For example in South Australia the age groups with the highest admission rates for deliberate self harm were the 20-24 year age group for the males and the 15-19 year age group for females. The admission rate for deliberate self harm attempts among females aged 10 to 24 years increased from 1990 to 1998 (Serafino et al, 2000). Data published in 2000 showed that in the year 1996 to 1997 the highest risk group for a deliberate self harm attempt was the age group 15 to 24, with the rates gradually decreasing in the older age groups.
These trends have also been reported elsewhere (Moscicki, 1997).

These rates need to be contrasted with the fact that older adults have comparatively higher suicide rates. While the ratio of attempted suicides to suicides in adolescents may be as high as 200:1, the ratio drops to 4:1 in later life. The difference in ratio has been attributed to reduced physical resilience, greater social isolation and greater determination to die (Conwell et al, 1998).

**Gender**

There are marked differences between the admission rates for males and females for deliberate self harm. Data published in 2000 showed that in 1998 the rates for females admitted to hospital after a self harming attempt were significantly higher compared to the male rates for all age groups; with the exception of the age group 30 to 34 where the admissions were almost equal. Overall there were 74% more females who had attempted to harm themselves. Overdose by solid or liquid substance was by far the most common method used among self harm hospital separations for both males (70% of hospital admissions for deliberate self harm) and females (85% of hospital admissions for deliberate self harm) (Steenkamp and Harrison, 2000).

**Risk factors associated with deliberate self harming behaviour**

Researchers from many disciplines have looked at the phenomenon of deliberate self harm and have tried to identify what people who engaged in this behaviour had in common. Various risk factors have been identified. These include: social factors; genetic and biological, family characteristics and childhood experiences, personality and beliefs, environmental factors and mental health/illness. Below is a summary of the factors associated with each of these categories.

**Societal factors**

**Social integration**

In 1897 Durkheim suggested that a person’s degree of integration within society was an essential component of suicidal behaviour. He argued that suicide rates vary in inverse proportion to the integration of an individual into society (Durkheim, 1951).

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1 It is important to contrast these ratios with the fact that a death by suicide is more frequent in men than women (Cantor et. al, 1998).
Others have further developed this theory and identified the causes of suicidal behaviours as lying within society. It has been hypothesised that a person who attempts suicide feels a sense of failure and anxiety in their personal life, as a result of many factors such as unemployment, family disintegration and relative poverty (Hassan and Tan 1989; Milbank, 1993). It has also been shown that individuals who report feeling less connected to the family, friends and/or the community are more likely to make a deliberate self-harm attempt (Joiner and Rud, 1996). A range of cultural factors such as changes in social values, increasing inequality, disadvantage, changing family structures may influence deliberate self-harming behaviour (Eckersly, 1996). Hassan (1996) argued that the young and the elderly in modern societies like Australia are stigmatised. The people in these age groups can experience high levels of dependency as factors such as prolonged unemployment, poverty, disability and ill health can reduce their ability to engage in the reciprocal social exchange. These factors may reduce their level of social integration and increase their sense of isolation. Inversely factors such as social support, good social relations and family connectedness have been identified as significant factors for good mental health and are protective against suicidal behaviour (De Leo et al, 1999).

**Unemployment**

A person’s position and integration within the workforce appear to have a significant influence on their vulnerability to suicidal behaviour. There is a negative correlation between socio-economic status and deliberate self-harming behaviour (Hassan, 1995). Unemployment has been consistently linked to suicidal behaviour (Krupinski et al, 1994; Beautrais et al, 1998). Even though a link has been identified, it is still unclear whether unemployment is a cause of suicidal behaviour and mental disorder or whether suicidal behaviour and unemployment both arise from similar causal factors. In a matched control study, Beautrais and colleagues (1998) found that, when both antecedent family/childhood factors and psychiatric morbidity were taken into account, unemployment was not significantly related to the risk of a suicide attempt. The association between unemployment and suicide risk appeared to arise from factors such as lack of formal educational qualifications, childhood sexual abuse, poor parental relationship and a low score on the Parental Bonding Instrument (PBI). These factors were antecedent to both the onset of unemployment and the suicide attempt. This study suggests that the association between unemployment and suicide attempts reflects the association that exists between
unemployment and psychiatric disorder (Beautrais et al, 1998). Platt and Hawton, in their comprehensive review on suicidal behaviour and the labour market, remarked:

Individual cross-sectional studies reveal an increased rate of suicide and deliberate self harm among the unemployed. Although the micro risk estimates [relative risk (RR) ratio and population attributable risk (PAR) percent] are high, particularly with respect to deliberate self-harm, suggesting a causal impact of unemployment, the evidence from several studies highlights the possible role for self-selection in accounting for the relationship between unemployment and deliberate self-harm. While aggregate cross-sectional studies do not present convincing evidence of an association between unemployment and suicide rates, unemployment and deliberate self harm across geographical areas within the same areas within the same country appear to be more closely related. (Platt and Hawton, 2000, p. 373 and 376)

Media influence

Reporting of suicide by the media has been shown to influence suicidal behaviour. Media representations of suicide can increase the incidence of suicide attempts (Martin, 1998). Celebrity suicides increased the ‘copy cat' effect 50% more than stories about non celebrities, suggesting that people identify more with the realm of the superior rather than the ordinary (Stack, 2000). Suicide stories generally, fictional portrayal of suicidal behaviour and television documentaries designed to inform and advise about suicide have also been seen to increase suicidal behaviour (Hassan, 1995).

Genetic and Biological factors
Family history of suicidal behaviour

Knowledge about biological aspects of suicidal behaviours has increased rapidly over the last two decades. Genetics and biology play an important part in suicidal behaviour and it has been shown that suicidal behaviour runs in the family (Brent et al 1996). In a comprehensive review on genetic factors and their influence on suicidal behaviour, Roy and colleagues found that a family history can be related to suicidal behaviour. In many suicide victims these genetic factors are involved in the genetic transmission of bipolar disorder, schizophrenia and alcoholism (Roy et al, 1997). A family history of suicide was found to significantly increase the risk for a suicide attempt in a wide variety of diagnoses. Almost half (48.6%) of those with a family history of suicide had themselves attempted suicide. A family history of suicide is
often associated with a violent suicide attempt. In a comprehensive review on the
genetic factors associated with suicidal behaviour Roy and colleagues (2000)
concluded:

> In summary, a large body of clinical data from family, twin
and adoption studies now shows that there is a genetic
susceptibility to suicide. However, this susceptibility is
only likely to manifest itself in an individual at times of
severe stress or when ill with a major psychiatric disorder
(Roy et al, 2000, p. 218).

**Chemical factors**

Post-mortem studies on suicide victims have found a reduced serotonergic activity,
and an increase in the post synaptic serotonin receptors in the prefrontal cortex in
suicide victims (Kety, 1986). Impaired serotonergic function is a correlate of serious
suicidal acts and of impulsive aggression towards others and property. Other
neurotransmitter systems such as noradrenergic, dopaminergic, GABAergic and
 glutamatergic are also implicated in a suicide attempt. Molecular studies have
highlighted polymorphism of the tryptophane hydrxylase gene as related to suicidal
behaviour. Tryptophane hydroxylase is the rate-limited enzyme in the synthesis of
serotonin and low turnover rate of this transmission is associated with impaired
impulse control. An increased number of serotonin neurones have been found in the
brains of suicide completers (Roy et al, 1997b). Based on these findings Roy et al,
1997b suggest that this represents a developmental disorder, probably of genetic
origin. The research into biological and genetic aspects of suicide and deliberate self
harm is still in its early stages and different results need to be treated cautiously
(Traskman-Bendz and Mann, 2000).

**Physical and health factors**

Chronic illness, physical disabilities and physical complaints have also been found to
be important factors in suicidal behaviour. Physical disorder may also carry more
weight as a risk factor with increasing age (De Leo et al, 1999).

**Environmental factors**

**Social stressors**

Social stressors have been found to be present in the majority of people who have
made a deliberate self harm attempt. Suicidal behaviour has been shown to follow
interpersonal problems and disputes, romantic rejection, marital separation or divorce
(Hawton and Catalan, 1987). It has been shown that the greater the overall number
of social stressors, the greater the likelihood of suicidal behaviour (Beautrais, 1998). Beautrais and colleagues (1997) noted that when inter-correlations between life events and antecedent social, family and personality factors were accounted for, interpersonal loss and conflicts and legal problems remained significant risk factors for serious suicide attempts (Beautrais et al, 1997).

**Family characteristics and childhood experiences**

**Tenuous family connections**

It has been demonstrated that people who engage in suicidal behaviour are more likely to have experienced family violence and abuse, changes in the social environment such as relationship breakdown, or conflict with their family. A person who is marginalised and isolated from their family of origin has an increased risk for suicidal behaviour (Beautrais et al, 1996).

**Negative childhood experiences**

Childhood abuse has been associated with many negative consequences for subsequent functioning of the victims. Suicidal behaviour can be one of these. Malinosky-Rummel and Hansen (1993), in a comprehensive review on the impact of childhood abuse on subsequent behaviour, noted that childhood maltreatment has been linked to adolescent self-injurious and suicidal behaviour. Brown and colleagues (1999) found that a history of child abuse or neglect predicted depressive disorders in adolescents and young adulthood and suicidal behaviour was also strongly associated with a history of maltreatment. The authors hypothesised that part of the relationship between childhood maltreatment and depression and suicidal behaviour can be explained by adverse contextual factors in the areas of family environment and parent-child characteristics. Different risks have been estimated according to the different types of childhood maltreatment. For example it has been shown that sexual abuse carries the greatest risk of subsequent depression and suicidal behaviour, independent of the contextual risk under which the abuse occurs. People who have been abused physically as well as sexually are more prone to making repeated suicide attempts (Brown et al, 1999).

**Parenting styles**

In addition to chaotic and abusive family backgrounds, other parenting styles have also been associated with an increased relative risk for depression. Intrusive and overprotective parenting styles can have an effect on the self-esteem of the children. The parental style can account for the differences between cases and non cases of depression, suicidal thought and deliberate self-harm. Assignments by adolescents
of their parents to the ‘affectionless/control’ quadrant of the Parental Bonding Inventory (PBI) increased the relative risk for depression and/or suicidal behaviour (Martin and Waite, 1994).

**Psychological factors, personality and beliefs**

**Coping styles**

It has been shown that it is not the presence of a social stressor itself but the way an individual perceives this stressor that is important. Healthy and well developed coping skills may buffer against stressful life events and decrease the likelihood of suicidal behaviours (Josepho and Putchnick, 1994). Cummins and colleagues (2002) propose the idea of a ‘homeostatic system of Subjective Well Being’. The important part of this process is based on whether or not the environmental circumstances challenge the homeostatic threshold of a person. If the balance is not challenged (i.e. habituation or adaptation occurs) the person will perceive that their needs have been met. However if the stressor challenges, for whatever reason, the homeostatic balance, the individual will experience difficulties in adapting to the stressor (Cummins et al, 2002). It could be hypothesised that a similar mechanism occurs in people who make an attempt to harm themselves.

**Personality traits**

Other approaches to understand coping styles suggest that suicidal patients tend to use all coping styles, with the exception of suppression, significantly less than non suicidal patients (Botsis et al, 1994). There is also a clear association between external locus of control and suicidal behaviour (Beautrais et al, 1999). Locus of control is a concept developed by Rotter and is to be seen as a continuum of behaviour. Internal locus of control is defined as when the perception of control over an event rests within the person. A person who has external locus of control attributes such control to external agencies such as luck or some powerful other person or force (Hjelle and Ziegler, 1992). Other personality traits such as dichotomous thinking (all-or-nothing thinking), cognitive restriction (losing sight of different options), hopelessness, problem solving deficits and over-general autobiographical memory (remembering events in a general way) have also been linked to suicidal behaviour (Williams, 1997). For example Williams and Broadbent (1986) found that people who had made a suicide attempt had an inappropriate memory retrieval system and tended to retrieve over-general memories, such as they were feeling ‘happy’ during the first years of their marriage. These individual characteristics are important to consider.
Cognitive restriction

Williams and Pollock (2000) described suicidal behaviour as an attempt to escape from a trap. The authors noted:

Suicidal behaviour is seen as a ‘cry of pain’ that is elicited by a combination of circumstances in which the person perceives him/herself to have been defeated, where there appears to be no possibility of escape or rescue, and where the means by which a person may harm him/herself is available. (Williams and Pollock, 2000 p. 89)

People who attempt to harm themselves feel trapped and cannot see any other way out of their situation than to harm themselves. Psychological aspects (such as individual coping strategies) and personal characteristics (such as personality styles, dichotomous thinking, problem solving deficits and over-general autobiographical memory), all contribute to the state of ‘feeling trapped’ (Williams and Pollock, 2000).

Psychiatric factors

Mental illness is a major risk factor for suicidal behaviour. It has been found that 70% to 90% of people who attempt to harm themselves have a diagnosable and treatable mental illness (Beautrais, 1996; Haw et al, 2001). The most common diagnoses associated with suicidal behaviour, in decreasing order, are: major and profound depression, chronic alcoholism and schizophrenia (Beautrais, 1996, Haw et al, 2001; Fry and Teesson, 1999; Wender et al).

Depression

Depression is consistently associated with suicidal behaviour. Up to 90% of people who attempt to harm themselves or die by suicide have been found to have depression at the time of their attempt (Beautrais, 1996; Fry and Teesson, 1999; Wender et al, Kety, 1986). Although depression is an important risk factor for suicidal behaviour, a depressed mood does not necessarily lead to a suicide attempt. In suicide attempts (as far as the depressive symptoms are concerned) agitation, hostility and feelings of hopelessness and helplessness are more prevalent then other cognitive characteristics of depression (Diekstra, 1993). It has been suggested that the levels of hopelessness, rather then depression per se, are more predictive of a suicide attempt (Kovacs et al, 1975).

Schizophrenia

Up to 10% of people who attempt to harm themselves have been diagnosed with schizophrenia (Beautrais, 1996) and although schizophrenia is a major risk factor for
suicide it is not, in itself, an indicator for suicide. There were no differences between the demographics and clinical characteristics of individuals with schizophrenia (or schizo-affective disorder) who have attempted to harm themselves with those who have not. Similarly the presence of depression increased the risk for suicidal behaviour, but did not allow for differentiation between the two groups (Harkavy-Friedman, 1999).

**Substance abuse**

Substance abuse, in particular alcohol abuse, also play a significant part in a person’s decision to harm themselves. It has been found that the abuse of substances, including alcohol, may be the second most frequent psychiatric precursor to suicidal behaviour (Murphy, 2000). Alcohol abuse has been linked to factors such as recent or impending interpersonal losses and co-morbid psychiatric disorders. These factors may be both a consequence of alcohol related behaviour and a precipitant to deliberate self harm (Hawton et al, 1997). Alcohol and marijuana are both depressants, and evidence has shown that they may be likely to precipitate or exacerbate depression when used together (Donaghy, 1997). It has also been hypothesised that excessive use of alcohol and drugs may be symptomatic of deeper problems and may exacerbate suicidal behaviour by causing impaired judgement (Hawton et al, 1997; Murphy, 2000).

**Personality disorder**

Different studies have found that people who attempt to harm themselves were more likely to have a definite personality (mainly borderline) disorder (Beautrais, 1996; Brent et al, 1993; Haw et al, 2001). Adolescent who have made suicide attempts had increased rates of paranoid, dependent, antisocial, avoidant, borderline and passive-aggressive personality disorders (Brent et al, 1993). Similar results have been found for adults. For example Haw and colleagues (2001) found that 51% of the people who had attempted to harm themselves had a personality disorder at the time of the attempt.

**Impulsivity, hostility and aggression**

Behavioural characteristics such as anger, hostility and impulsivity have been consistently linked to suicidal behaviours (Simon et al, 2001). Suicidal people manifest their anger and hostility in more intropunitive and covert ways with high levels of guilt and depression (Williams and Pollock, 2000). Brent and colleagues (1993) argued that both suicidal behaviour and violence stem from the same underlying aggressive impulse. Suicidal behaviour and violence are both multi-
determined acts that can be seen to be influenced by the same environmental factors, psychiatric diagnoses and biological predispositions. Environmental factors such as violence in the home, a deviant family background, unemployment, overcrowding and accessibility to lethal means, as well as the availability of alcohol and other drugs have been linked to suicidal behaviour as well as violent behaviours (Nock and Marzuk, 2000).

**Previous and patterns of attempts**
Suicide attempters constitute a high risk group for further attempts; a past attempt is one of the major risk factors for future suicide attempts (Hjemeland, 1996). Some studies have suggested that the risk of repeat attempt is the highest in the year following the attempt (Ostamo and Lonnqvist, 2001).

Different patterns of attempters have been identified and different classifications have been offered. Bancroft and Marsack (1977) described three groups of attempters. These groups are: 1) the chronic, habitual repeaters, who move from one crisis to another, with overdosing as their habitual way of coping; 2) the individual who repeats several times within a few months in reaction to relatively prolonged periods of stress such as marital conflict. The people in this group do not attempt for a long time after the initial series of attempts; and 3) the very rare repeaters, who have only attempted to harm themselves on one or two occasions throughout their lives (Bancroft and Marsack, 1977). Similarly Kreitman and Casey (1988) divided their group into: 1) “first ever”, who had not made a previous attempt; 2) “Minor repeaters” who had a lifetime history of two to four attempts; and 3) “major” or “grand attempters”, who had made five attempts or more. They reported that over a 20 year period, 40 to 60% were “first ever”, which implies that half the admissions were repetitions.

**Protective factors**
Recently research has explored more closely why people under difficult life circumstances do not resort to suicide. There is still relatively little information concerning protective factors for suicide; However, a range of protective factors have been extrapolated from the evidence on risk factors. Protective factors for suicidal behaviour are not the topic of the study aims and will only be briefly mentioned in this document. Individuals who are well connected to their family and friends are less likely to attempt to harm themselves (Resnick et al, 1997). Healthy and well developed coping skills have been found to have a buffering effect for stressful life events (Josepho and Plutchick, 1994). The likelihood of a suicide attempt may vary
with religious beliefs as well as the extent of involvement in religious activities. For example individuals are less likely to act on suicidal thoughts when they have a strong religious faith and believe that suicide is morally wrong or sinful (Resnick et al 1997).

**Conclusion risk factors**

A large number of contributing factors have been identified as having a significant impact on the phenomenon of suicide. These include: age and gender, physical illness (De Leo et al, 1999; Cantor et al, 1998) psychiatric and personality disorders (Baume, 1996; Brent et al, 1994; Beautrais, 1996), drug and alcohol use (Murphy, 2000), social factors/stressors (Jacobs et al, 2003), different coping styles (Botsis et al, 1994) personality characteristics such as neuroticism and external locus of control (Beautrais, et al, 1998), dichotomous thinking, cognitive restriction, hopelessness, problem solving deficits and over-general autobiographical memory (Williams, 1986; Williams and Pollock, 2000), as well as behaviour characteristics such as impulsive and violent behaviour (Brent et al, 1993). The complexity of the phenomenon of suicide and deliberate self harming behaviour is obvious. Each of these risk factors is seen to contribute to an attempt in different ways. The mere presence or absence of one or more of these risk factor does not necessarily predict a suicide attempt (Goldney, 1998). There is a constant interaction between individuals and their environment in the development of suicidal behaviour (Van Heeringen et al, 2000). Social circumstances such as unemployment or family break-up do not necessarily lead to suicide but they can significantly lower the person’s threshold and make them more vulnerable to mental illness and therefore increase the risk of suicide (Paris, 1992). On the other hand a person who is having mental health problems, will find it more difficult to deal with stressful life circumstances, and therefore be at an increased risk for suicide (Jacobs et al, 2003).

A particular risk factor, such as depression, can at times influence the decision to self harm in a direct way, while in other cases factors such as adverse childhood experiences impact on feelings of depression which, in turn, influence the depressed feelings which then influence the decision to self harm in a more indirect way. In this particular scenario, the childhood experiences combined with the depressed feelings associated with these influences the decision to self harm. A suicide attempt is the result of the interaction of different individual, social, psychiatric, psychological and biological factors. These can be seen in figure 2.1 which displays an adapted form of a model proposed by Beautrais.
The model highlights the interplay between biological and genetic, societal and demographic factors, family characteristics personality and beliefs with environmental and mental health/illness problems that may lead to a deliberate self harm attempt. Furthermore the model highlights the complexity of the different variables involved. As a result it is necessary to consider all the variables in order to account for a suicide attempt and each of these variables can influence the deliberate self harm attempt in different ways.

**Identified subgroups**

In many ways, non-fatal suicidal behaviours differ enormously (Kerkhof, 2000). Certain characteristics of subgroups of people who attempt to harm themselves have been identified. The studies investigating subgroups have classified the participants either by psychiatric illnesses (Soloff et al, 2000; Isometsa et al, 1997; Heila et al,
Classification by psychiatric diagnoses

People who have made a deliberate self harm attempt are likely to have a diagnosis of mental illness (Beautrais, 1996). The next section will describe the characteristics that appear to be associated with people who have made a deliberate self harm attempt and have been diagnosed with major depression, schizophrenia, drug and alcohol abuse, personality disorders (borderline and anti social) and those who exhibit behavioural characteristics such as violent and impulsive behaviour.

Major depression

When compared to other patients who had made a deliberate self harm attempt, patients who were diagnosed with major depression (with or without co-morbid disorders) had significantly greater observer-rated depression relative to the Hamilton Depression Scale), higher levels of life-time depression (Soloff et al, 2000) and high levels of hopelessness (Suominen et al, 1997). In addition the attempt was less likely to be impulsive (Suominen et al, 1997) and they generally described higher levels of suicide intent/wish to die (Suominen et al, 1997; Groholt et al, 2000; O'Brien et al, 1987). They were also less likely to report interpersonal loss and conflict (Suominen et al, 1997; Rich et al, 1988).

Some studies reported that patients diagnosed with major depression who had made an attempt were significantly older than those who had an associated diagnosis of borderline personality disorder (Soloff et al, 2000, O'Brien et al, 1987). These findings were not replicated in another study where factors such as age, sex, repeater status, anxiety disorder or Axis II diagnosis did not appear to be significant factors differentiating those who were diagnosed with major depression to those who had an associated diagnosis of borderline personality disorder or alcohol abuse (Suominen et al, 1997).

Schizophrenia

People diagnosed with schizophrenia or psychotic disorders who made a deliberate self harm attempt were characterised by social withdrawal, social skills deficits and lack of social contact (Radomsky, 1999). They were also more socially isolated and unable to maintain relationships because of their illness. Life events and social stressors were less prominent in this group. The suicidal behaviour was more likely to occur in the active phases of the illness and appeared to be associated with internal illness related factors such as hearing voices (Heila et al, 1999). Radomsky
(1999) also noted that it is during the early stages of the illness that participants who have schizophrenia often attempt to harm themselves.

**Personality disorder**

*Borderline personality disorder*

People with a borderline personality disorder who have made an attempt (compared to people with a diagnosed of major depression) showed higher levels of subjective distress which were disproportionate to objective findings (Soloff et al, 2000). For these patients the depression was marked by emptiness, loneliness, diffuse negative affectivity (including anger, loneliness, fear and desperation), markedly inconstant self concept and self-esteem, dependency, fears of abandonment, and related interpersonal concerns (Soloff et al 2000; Westen et al, 1992). In addition this group was also significantly younger, had made their first suicide attempt at an earlier time in life and were more likely to have a larger number of attempts (Soloff et al, 2000, Westen et al, 1992). A strong association between alcohol abuse and borderline personality has also been noted (Alessi et al, 1984).

*Anti-social personality disorder*

Compared to other patients who had made an attempt, adolescents who are diagnosed with antisocial personality disorder, were more likely to have made an attempt under the influence of alcohol, to have experienced a separation from their parents and to come from a violent family background where parents abuse alcohol. Other factors such as having less social support and experiencing relationship difficulties were also more frequent in this group (Marttunen et al, 1994).

**Drug and alcohol abuse**

Hawton and colleagues (1997) found that patients who abused drug and/or alcohol and had made a deliberate self harm attempt were more likely to be male, to be over the age of 35, to report a history of childhood abuse, to be unemployed, to have made previous attempts, to have social stressors (mainly problems with a relationship, housing and legal problems) and to have consumed alcohol at the time of the event. Other risk factors such as problems in relationship with a partner were also more prevalent in this group (Hawton et al, 1997).

Other studies regrouped participants according to the type of attempt, motives and/or intent of the attempt. These groupings will now be described.
**Motives for attempt**

Bancroft and colleagues (1976) described three main groups of motives for an attempt. The groups were: 1) to obtain relief or escape from a situation; 2) to influence someone; and 3) to make things easier for others. These three groups had very distinct characteristics.

1) To obtain relief or escape from a situation.

The group that attempted in order to obtain relief or escape from a situation was divided into two subgroups:

(a) Those who attempted because they were worried about the future, sorry or ashamed of something, failed in life, or sought relief from a state of mind. This group was characterised by: previous attempts, a psychiatric history, no current relationship and a positive association with attempting to seek help before the overdose.

(b) Those who attempted because they were angry with someone, tried to seek help or tried to escape from an impossible situation, or were feeling lonely or unwanted. This group was characterised by social isolation, frequent financial and employment difficulties and no stable accommodation. Escape in this context is more often associated with escape from people rather than situations.

2) To influence someone, to make others sorry or to try and get revenge on someone (including trying to show how much they loved someone). This group was characterised by patients being under the age of 21 who were experiencing relationship problems. It was usually their first attempt.

3) Wanting to make things easier for others. This group was characterised by needing help with money or material goods and having accommodation problems (Bancroft et al, 1976).

**Suicide intent**

Similarly Hamdi and colleagues subdivided their groups into those with low and medium suicidal intent.

The low intent group was characterised by people who stated that they did not want to die and the attempt was more likely to be motivated by anger and frustration at some aspect of their immediate life situation. The act of self-harm was often aimed at influencing the environment. Furthermore the aggressive feelings were directed inwards in order to punish or make others feel guilty. In this context the attempt
aimed to relieve or undo any preceding difficulties. The low intent is a desperate attempt to maintain rather than sever the relation to the external world. The people in the high intent group had planned and decided that they should die. In this group feelings of hopelessness and isolation were prominent. This group was older, were more frequently married, and had a higher proportion of psychotic issues and a higher score of ideo-affective states. There were no differences between the two groups in regards to feelings of loss, helplessness, inadequacy, self-hatred and guilt (Hamdi et al, 1991).

More recently Groholt and colleagues (2000) also found an association between the intent of the self harm attempt with other identified risk factors. Adolescents who stated that they wanted to die were more likely to be depressed, lonely, less hopeful for the future, and were less explicit with wanting help with the problems they were experiencing. Adolescents who did not state a wish to die were more likely to be disruptive, impulsive and overwhelmed by acute problems (mainly interpersonal problems). This group more often reported that they felt they had lost control of their feelings and wanted help for the problems they were dealing with. They were more likely to see their future with some optimism. (Groholt et al, 2000)

Similarly Simon and Colleagues (2001) noted that impulsive suicide attempts appear to be immediately preceded by interpersonal conflicts. Impulsive suicide attempts tended to occur more often among attempters who had been in a physical fight in the year prior to their attempt. Furthermore the authors suggest that impulsive attempts were more likely for subjects that scored relatively low on depression scales and were involved in physical fights. An impulsive suicide attempts might be a response to these conflicts rather than an actual desire to die (Simon et al, 2001).

**Conclusion**

Durkheim more than 100 years ago showed that based on a person’s integration in society there were three specific groups of people who attempted to kill themselves. From this review it has emerged that social integration is one of many factors that need to be taken into account when attempting to subdivide the different people who attempt to harm themselves. Other factors such as age, gender, psychiatric diagnoses, behavioural characteristics, life events, motives and intent will also need to be taken into account.

Each individual story leading up to an attempt is unique, and each individual experiences, in Shneidman’s term, extreme feelings of ‘Psychache’ (Shneidman, 1993). However, there is a suggestion that subgroups of people who attempt to harm
themselves, who have similar characteristic can be identified. It was suggested in the literature that intent/motive as well as different risk factors associated with a deliberate self harm attempt may help to delineate different sub-types of self harmers. This research will explore individual stories of people who have attempted to harm themselves in a systematic way, and will attempt to reconstruct life histories behind a suicide attempt, taking into account risk factors such as age and gender and the social context, as well as individual life experiences and social stressors, behavioural aspects, psychiatric and psychological factors, the events leading up to the attempt and the motive and meaning of the attempt. By focusing on the combination of different risk factors, it is anticipated that some of the subgroups identified within the literature may be further refined.
Chapter 3: Methodology

Investigating a phenomenon as complex as suicide or deliberate self harming behaviour is not without difficulties. In the previous chapter it was noted that a large variety of risk factors interact in the decision to self harm (Hawton and Van Heeringen, 2000b). O’Donnell and colleagues suggest that an understanding of the way those who have made a serious attempt on their lives explain their actions is essential in the development of effective prevention strategies (O'Donnell et al, 1996). A similar concern was also noted by Hawton and Van Heeringen (2000b) in their comprehensive *International Handbook of Suicide and Attempted Suicide* when they recommended:

> In future, therefore, it is likely that there will be much more emphasis on investigations of survivors of serious suicide attempts, who can be viewed as living would-be victims. (Hawton and Van Heeringen, 2000b, p. 715)

This research explores the life story of individuals up to and just after the point at which they have made a deliberate self harm attempt. To this end the following aims were developed:

1. To investigate the presence of risk factors known to be associated with deliberate self harming behaviour;
2. To determine the stated motives for deliberate self harming behaviour of people who have come to the attention of the Accident and Emergency Department of Westmead Hospital after an attempt to harm themselves; and
3. To investigate the relationship between risk factors and the reason people give for self harm.

The overall aim is to gain an in-depth understanding of deliberate self harm, taking into account risk factors and stated motives for attempt.

**Epistemology**

This research places itself in a constructivist framework. In this approach, the process of discovery underpins the research enterprise. In a constructivist study meanings are described, interpreted and constructed through the eyes of the researcher or the participants in the investigation. Meanings are constructed by
human beings as they engage with the world they are interpreting (Minichiello et al, 1999). Crotty (1998) described the constructionist framework as following:

Meaning is not discovered, but constructed. In this understanding of knowledge, it is clear that different people may construct meanings in different ways, even in relation to the same phenomenon. [...] In this view of things, subject and object emerge as partners in the generation of meaning. (Crotty, 1998 p. 9)

From the constructivist viewpoint, meaning cannot be described simply as ‘objective’ or ‘subjective’. The world and objects in the world may be in themselves meaningless; yet they are partners in generating meaning. Subject and object, distinguishable as they are, are always interrelated. The meaning of an object is not just there; it is always an ongoing accomplishment (Crotty, 1998). Human behaviour is different in kind from inanimate objects as people are uniquely conscious of their own behaviour. The significance of people’s actions lies in their individual perspectives and the meanings they attach to situations.

This research focused on understanding a suicide attempt from the perspective of those who attempted to harm themselves and came to the attention of the Westmead Hospital Accident and Emergency Department. The events leading up to the attempt and the motives and meaning of the attempt were re-constructed by an in depth interview, performed as close as possible to the event between the research participants and the interviewer in the context of the emergency department. A psychiatric assessment also formed part of the data collection process. The history and identification of risk factors occurring during the assessment can also be seen as constructed by the respondent and the assessing psychiatrist.

**Theoretical Position**

An interpretivist position underpinned the research. The interpretivist approach looks for culturally derived and historically situated interpretations of the social life-world (Crotty, 1998). Interpretivism has been linked to the thoughts of Max Weber, who contrasted the interpretive approach *Verstehen* (understanding) needed in the human and social sciences with the explicative approach *Erklären* (explaining), which focuses on causality, that is found in the natural sciences. There is a need to focus the social inquiry on the meanings and values of each person and therefore their subjective “meaning complex of action” (Crotty, 1998).
Methodology

In this study a mixed method approach, which uses both qualitative and quantitative data, has been adopted to explore known risk factors, intention and motive of the act.

Qualitative research is premised on a belief that the participant’s voice is fundamental to any understanding of the topic under investigation and in this research qualitative data were collected on the subjective experiences of the research participants. Qualitative methods such as in-depth interviewing are said to allow the researcher to gain access to the motives, meanings, actions and reactions of people in the context of their own lives (Minichiello et al, 1999).

The use of a semi-guided interview allowed the data collected to reflect the mental state of people who self-harmed, the events leading up to the attempt and the state of mind and feelings about the attempt as expressed in the words of the participants.

Quantitative data also collected from the psychiatric interview and medical files provided the descriptive statistics. The data collected in this manner looked at demographics, psychiatric diagnosis, contact with the health department and investigations undertaken.

This research project combined methods taken from the quantitative and qualitative research traditions. This approach is not without theoretical difficulties. Both approaches have their strengths and weaknesses. Qualitative research allows an in depth understanding of the phenomena, but is generally very labour intensive and only allows the analysis of small numbers. Quantitative research allows for research on larger numbers but does not allow an in-depth analysis in the way that qualitative research enables (Minichiello et al, 1999). Combining both methodologies allows compensation for the weaknesses of one, by the strengths of the other (Rice and Ezzy, 1999). However, this is not without methodological and philosophical difficulties. Oakley (2000) noted that quantitative researchers are committed to the traditions of natural science and medicine, and base their research on “facts” in an aim to investigate the causes of the social phenomenon. Quantitative research assumes that the reality investigated is stable. The methods utilised are obtrusive and objective and the researcher is conceptualised as being an objective outsider. On the other hand, qualitative researchers view events and situations from the perspective of the researched and are concerned with the understanding of the subjects’ own frames of reference. The methodologies utilised are naturalistic and
uncontrolled. Data are considered to be subjective and the researcher is close to the data and is conceptualised as being an insider (Oakley, 2000).

In the past, situations have arisen where personal perception or daily experiences of a phenomenon have offered one answer and objective measurements another, and the differences within the findings were utilised to validate or invalidate the different methodologies used. However; more recent attempts however to combine different research methodologies have focussed on combining the two research methodologies in order to explain the contradictory findings (Bryman, 1992). The aim is to seek convergence in data and to establish a more complete picture of the phenomenon by combining different perspectives (Rice and Ezzy, 1999).

Such an approach acknowledges that, while there are differences between the different research methodologies, there are also a number of points where the two research traditions come together and where the differences are not as rigid as the philosophies behind the research traditions seem to imply (Bryman, 1992). Both research methods are used for the observation of social phenomena and have internal mechanisms to ensure the quality of the data collected. When these mechanisms are observed the data obtained can provide valuable insight into the phenomenon under investigation and when the two types of data collection/analysis support one another, one can have greater confidence in what has been revealed.

In the current study it was found that both types of data complemented each other. Both types of data revealed similar patterns. The quantitative data identified patterns and trends within the data, whereas the qualitative data allowed for a deeper understanding of these patterns. The focus of the study was not to reveal causal relationships, but to discover how the deliberate self harming attempt was experienced by the research participants.

**Research design**

This study aimed to explore an increasingly complex understanding of self harming behaviour and incorporate personal meanings and motives given for the act and risk factors. This study adopted an exploratory, mixed method research design which included quantitative and qualitative data coming from the psychiatric assessment interview, the research interview and the medical files.

**Meeting the needs of the researched**

Different ethical concerns are present when interviewing people as vulnerable as those who have made an attempt to harm themselves and have come to the
attention of a hospital emergency department. The research design of this study was adjusted to incorporate the different ethical concerns and the needs of the research participants. As Beskow and his colleagues noted:

> Adjusting the research design to conform to ethical principles should not decrease but may increase the quality of the data. (Beskow et al, 1990, p. 485)

The interview was designed to, at the very least, not do any harm and, when possible, enhance the treatment provided. The choice of the interview guide and techniques was guided by the vulnerability and mental state of the research participants in this research. In addition, because the research was being conducted in a large hospital, it was necessary for the research to integrate into the hospital practices and not to interfere with the treatment offered.

The research design for this project had to balance the following different needs:

- The needs of the research as such, which was to collect accurate and appropriate data;
- The needs of the research participants for care and appropriate treatment and to ensure that they were not subject to any harm; and
- The need to conduct the research within a hospital context without interfering with the medical treatment.

The following research protocol was designed to meet the needs identified above.

**Approach**

All people who have been admitted to the Emergency Department of Westmead Hospital after an overdose (including accidental) and self injuries are seen by the Liaison Psychiatry Team. Part of the information necessary to this research project was routinely collected by the Psychiatric Assessment Team. In order to avoid the participants having to repeat this information permission was sought by the researcher (myself) to sit in on the psychiatric assessment. At the end of the psychiatric interview the researcher re-introduced herself to the patient and explained the aims of the research project, as well as the research participants’ right to refuse to participate. After this was explained the participants were invited into the study. Permission was also sought to tape the interviews for further qualitative analysis. This interview was separate to the psychiatric assessment. The data were collected from 21st March 2000 until 5th April 2001. Weekends were also included in the sampling period.
Timing and place of the interviews
In order to explore the “mind frame” of people who attempted to harm themselves, in a way that would minimise the impact of rationalisation and family pressure, the interviews were undertaken as soon as possible after the event. Most of the interviews (91%) were performed within 24 hours of the patients awakening, with more than half (53%) of the sample interviewed within 12 hours of their awakening (see table 3.1 for details). Most of the interviews were done in the Emergency Department (64%). The others were performed either in a private room (18%), or on the hospital ward (17%). One interview was performed in the Intensive Care Unit (see table 3.2 for detail). The researcher was present during most of the psychiatric assessment for 70 (78%). Four (4%) of the interviews were performed with the aid of an interpreter.

Table 3.1: Time between awakening and interview

<table>
<thead>
<tr>
<th>Time</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 12 hours</td>
<td>48</td>
<td>53</td>
</tr>
<tr>
<td>12 to 24 hours</td>
<td>34</td>
<td>38</td>
</tr>
<tr>
<td>25 to 48 hours</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2 days to 1 week</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>More than 1 week</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 3.2: Place of the attempt

<table>
<thead>
<tr>
<th>Place</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department</td>
<td>58</td>
<td>64</td>
</tr>
<tr>
<td>Private room</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Ward</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>ICU</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Inclusion criteria
Hawton and Van Heeringen (2000a) noted that one of the most serious conceptual problems inherent in interviewing people who have made a serious deliberate self harm attempt is the difficulty in defining what constitutes a “severe attempt”. Medical seriousness of the attempt alone is not enough to define what constitutes a serious act of self-harm or even suicide attempt and other aspects such as intention of the attempt and understanding of the lethality of the methods need to be included.

Because of rounding the percentages reported on in this thesis may not add up to 100.
There are currently no standard criteria for the identification of individuals who should be included. In this study all people who had come to the attention of the emergency department and defined their attempt as deliberate self harm were included into the sample regardless of the lethality of the method utilised. In order to be included there also needed to be clear evidence that there was some deliberate action on their behalf.

As noted previously the researcher was part of the Adult Liaison Psychiatry Team. The Adult Liaison Psychiatry Team sees patients between the ages of 18 and 65 as well as those patients who are aged 17 and not attending school. For practical reasons it was not feasible to be integrated within the different psychiatric assessment teams in the hospital, and for these reasons only patients seen by the Adult Liaison Psychiatry Team were included in the sample.

In this study, all patients who were seen by the Adult Liaison Psychiatry Team of Westmead Hospital and who defined their self harm attempt as deliberate were included in the study, regardless of the medical consequences of their attempt.

Exclusion criteria
People who were too cognitively impaired at the time of the assessment and were unable to give informed consent were excluded from the research. This exclusion criterion was not without difficulties. As was noted in the literature review a large percentage of people who attempt to harm themselves have a mental illness at the time of the event. The presence of mental illness does not imply that, at the time of the interview, they do not have the capacity to give informed consent.

In the past, people with a mental illness were seen to be broadly incompetent (Michaels, 1999). Because of this view their civil liberties were curtailed and involuntary treatment was common. In 1993 the Burdekin Report into the Human Rights of People with Mental Illness in Australia recommended that people with a mental illness are to be given the same rights as other people, unless these rights endangered themselves or others (Burdekin, 1993). Today there are few people with a mental illness who are in hospital against their will and even those who are, retain their rights including the right to refuse treatment. This thinking has had an impact on research with people with a mental illness. People with a mental illness are now considered to be fundamentally similar to people with other medical conditions, and are protected and governed by the same safeguards and regulations. These regulations are based on functional characteristics such as decision-making capacity rather than diagnostic categories.
An argument can be mounted that because of the effects of psychiatric illnesses on people’s thinking, people who have these conditions should not be included in any research studies as they are vulnerable to being exploited. On the other hand a counter argument would be that it is unethical to exclude people on the simple basis of their illness. As Michaels (1999) points out, people with a mental illness who might have impaired decision-making capacity do not have one problem in relation to research ethics but they have two. The inability for such a person to provide fully informed consent may leave them vulnerable to exploitation, but the greater problem is that too little research is conducted on their behalf and that this neglect will continue.

Consent for people with a mental illness is a particularly difficult area to regulate as the mental illness can impair many different areas of the person’s ability to make decisions, and there are no clear guidelines on how to apply these criteria to assess ability to give consent. In this research project the issues surrounding the ability to give informed consent had to be dealt with on a daily basis, as the majority of the people interviewed either had a mental illness or impaired cognition due to alcohol abuse and/or mild mental disability. There were cases where the decision was obvious because the person was too delusional or too cognitively impaired to give informed consent.

However, the capacity to give informed consent was more difficult to evaluate for the “in-between” cases. The criteria that were applied in this research project were:

1) An assessment of their ability to understand the difference between a research interview and the clinical interview, and confirmation that this was understood;

2) A judgement that they were orientated in “time, person and space”. This cognitive assessment is routinely performed during the psychiatric assessment interview. During the psychiatric assessment the researcher was able to ascertain whether the person understood, processed and answered the questions in the psychiatric interview in an appropriate manner. When the researcher did not sit in on the actual assessment, this information was sought from the treating registrar.

A particularly difficult type of patient to assess, in terms of their ability to give informed consent, was the patient diagnosed with schizophrenia. As noted in the literature review schizophrenia is of particular concern because 10% of people who have schizophrenia will die by suicide and many more will attempt to harm
themselves. Although this group is at a high risk of suicide, there is little information available on the characteristics of those who attempt suicide (Harkavy-Friedman, 1999).

In the context of a person with schizophrenia, it has been noted that in order to give informed consent, a person should be free of delusions at the time of the interview. However, hearing voices cannot be viewed as an exclusion criterion as such. In order to determine whether a person is able to give informed consent, researchers have to utilise their clinical judgement rather than purely diagnostic criteria. Carpenter and colleagues (2000) noted that cognition is more relevant than psychosis in predicting decisional capacity in people who have schizophrenia. This implies that the proposition that a psychotic person ipso facto should lose decision-making power for research decisions is flawed and stigmatising. The authors concluded that rather than restrict research participation for categories of patients, emphasis should be placed on ensure that there are procedures for informing, and as well as more adequately documenting the way in which information has been provided and consent has been given.

The sample for this research included people who had schizophrenia, a manic episode or a mild cognitive impairment at the time of the interview. Because of the high self-harm and suicide rates in these populations it was important to include these experiences within the research. It was the clinical judgment of the psychiatric registrar and the researcher that allowed for the inclusion or exclusion of these cases.

Below are some details taken from the researcher’s case notes of how these principles were applied in selected cases that were included into the sample.

RP 37: 27 year old female, diagnosed with bi-polar disorder. She took an overdose to escape a sexual relationship. When she was asked to participate in the study she stated that she would do anything for research into mania. In addition she made the interviewer write and sign on the back of the consent form that the information obtained throughout the interview should remain confidential and that she would not reveal the identity of the research participants to anybody other than the co-investigators. One third of the way into the interview she was distracted and walked out of the interview to have a cigarette and the interview was stopped. Adequate information had been gathered to enable her data to be considered adequate for the purpose of the research.
RP 91: 21 year old male who was hearing voices at the time of the interview. At the end of the interview he stated that he hoped that his participation in the study would help somebody else.

Participants were excluded from the study when:

- There was clear evidence that the overdose was accidental;
- The person was too cognitively impaired, psychotic or too aggressive to be interviewed; and/or
- The person denied any deliberate self-harming intent.

**Sample:**
A total 128 people who had made a deliberate self harm attempt were approached. Of these 22 were excluded from the sample. The excluded people from the sample consisted of:

- Seven people who were too cognitively impaired to be interviewed;
- Twelve people who were psychotic at the time of the interview;
- One person who was too aggressive to be interviewed; and
- Two people who denied that their attempt was deliberate.

A further ten people refused to participate in the study. A total of 96 people were interviewed (participation rate 90%\(^3\)). However three of these were not included in the final analysis. This was because while they initially fitted the inclusion criteria, it emerged that the events did not include any deliberate actions on their behalf, and the events were described as a relapse into their drug and alcohol use\(^4\). In addition the information collected for three additional cases was insufficient and also excluded. As a result a total of 90 people were included into the final sample.

**The interview**

**The interview outline**
Constructing the interview outline itself was difficult due to the nature of the topic and the fact that the interview guide had to be designed in a manner that allowed the data to be collected in a systematic way, while at the same time either remaining neutral or having a therapeutic impact on the research participants. Training workshops on

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\(^3\) Percentage calculated on those that fulfilled the inclusion criteria.

\(^4\) In all three cases the interviewer was not present during the psychiatric assessment and was therefore unable to ascertain at the onset of the interview if the attempt was deliberate or accidental.
suicide emphasise the need to discuss the suicidal thought and/or attempt. In cases where a person does feel suicidal, it is recommended that this be identified by asking directly about suicide and by listening without judging in order to encourage the person to do most of the talking (Chipps and Katrakis, 1998).

The guidelines issued by the World Health Organisation (Treatment Protocol Project, 1997) suggest that when a person has attempted to harm themselves it is important, above all, to establish a rapport with them. Further it is important to try to understand the attempt by taking down the sequential details of the event, circumstances around the act and whether or not there have been previous attempts. After establishing these, the interviewer should start exploring any difficulties the person is currently experiencing, and to look for evidence of any psychiatric disorders. It is also important to make an assessment of the psychological and physical problems the person might be experiencing. Information about their background and their usual coping methods is also desirable. The guidelines also suggest ending such an assessment by exploring whether help is required, and if necessary drawing up a contract between the treating clinician and the patient.

The interview structure for the current project was based on a semi-structured interview outline, which followed the World Health Organisation’s guidelines on suicide assessment. The areas covered by the interview were as follows: mental health assessment; the events leading up to the attempt and previous attempts; personal and family history; previous medical and psychiatric history; drug and alcohol use; pre-morbid personality; coping ability; and present and previous contact with health services/welfare. The interview ended by reinforcing the positive aspects that were mentioned in the interview and, when appropriate, with a discussion around the participants hopes for the future.

The interview was designed to maximise any possible therapeutic impact on the research participants. Therapeutic elements of the interview were based mainly on the basic principles of counselling outlined by Carl Rogers. Roger asserts that a good relationship with the client is not only necessary, but in and of itself, can be sufficient for constructive changes to occur. The core conditions for a good counselling relationship are empathic listing, respect for the clients’ potential to lead their own lives and genuineness on the part of the clinician. Terms like active listening are other ways of expressing the central skills of the basic helping relationship (Nelson-Jones, 1997). For these reasons the interviews followed a conversational style rather

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5 For a detailed interview outline see Appendix 1
than an interrogative style of questioning, guided by a list of topic areas to be covered. As noted previously, this format allowed the research participant to express the events and feelings in their own words, and allowed the interviewer to assess the needs of each of the research participants, and to adopt a counselling and reflective listening approach if the need arose. Throughout the interview it was made clear to the research participants that they were allowed to decline to talk about any particular topics. Questions around sensitive topics such as child abuse were only kept to ‘factual’ information, and if any of these topics did arise throughout the interview no specific details about the event were asked.

**Interview technique**

Historically, social scientists have been taught to interact with research participants in a value neutral way. It was considered that the interviewer should always keep in mind that the interviewee is the *object* of the study (Bergen, 1993). When interviewing people who are vulnerable, this type of approach poses a number of issues. Firstly it is almost impossible for the interviewer to remain neutral and objective throughout the interview. In addition people who have just made a deliberate self harm attempt are extremely vulnerable and at a crisis point in their lives, and interviewing them about their attempt, without addressing any of the issues that might arise during the interview, would be unethical. Miess (1983) advocated for what she called a “conscious partiality”. This approach stresses the importance of the partial identification with the participants. It is based on personal interaction and the treatment of participants as subjects with real emotions and feelings. Bergen (1993) noted that the most valuable aspect of interviewing with conscious partiality is that the researchers are forced to de-objectify the participants and to critically examine how the research might affect the research participants as real people rather than as research subjects. At times this can be difficult to judge, as it is not known what aspect of the interview may continue to be felt well after the research interview. However, by observing the above principles, negative consequences can be minimised.

It could be argued that this method of interviewing introduces additional biases within the data collection and that the variation between interviewers would be great. There is no doubt that in interviews of this kind, exact wording and order in which the answers are given will vary according to the way in which the interview proceeds, but that the content, emotions and feelings expressed in the interviews remain similar. The information collected through interviews with ‘conscious partiality’ enhances the quality of the interviews. Listening in an empathic manner enhances the quality of the
data collected as the interviewee feels understood and safe to talk about different aspects of their life. In addition, through in depth interviewing people are able to tell their stories in their own words and in their natural language. Interviewing in this manner also allows for the interviewer to address any particular issues that might arise during the interview.

Different debates in the social sciences have been held around the issues of subjectivity and objectivity of this kind of research, in particular around the issue of interviewer bias. This debate will be briefly mentioned in this document. It is the author’s belief that exploring a culture, a social situation or another person’s reality (as is the case of this research) will inevitably have to take into account the subjectivity of the different interactions between actors and observers. It is impossible to be fully objective, to make full abstraction of our own culture. Our own culture and personality are important tools in the understanding of others, in that clashes and interactions between our own culture and the one observed are full of meaning (Rice and Ezzy, 1999). In addition, in the qualitative research tradition it is a commonly held belief that it is not possible to be objective, as when investigating any problem, researchers hold a set of assumptions based on their experience and beliefs, and that the act of research often changes what is investigated (Bryman, 1992). Tools have been developed to minimise the impact of interviewer bias, and these will be discussed later in this chapter.

**Skills of the interviewer**

When interviewing people who are in a vulnerable state, their welfare should remain the primary concern throughout the interview. Researchers have the responsibility to take account of the effects of their actions on the participants and to preserve the participants’ rights and well-being (Davidson, 1997). This implies that, in order to conduct research into sensitive areas, the researcher needs to have an in depth understanding of the different issues that interviewees might be facing.

In this research project the participants were still under psychiatric care when they were interviewed, but it remained important for the researcher to have the intervention skills to be able to address any emotional situation that might arise at any point in the interview. The author was the sole interviewer on this research. Prior to the research the author had training in bereavement counselling as well as research experience in the data collection on sensitive topics. The author also attended training provided by the South Western Sydney Area Health Service on suicide assessment as well as the Western Sydney Lifeline training course for
telephone counselling. The author also had been a Lifeline counsellor for over a year in preparation for the interviews. This experience proved to be invaluable for the conducting this research. Whilst the interviews were conducted primarily as a means to acquiring research data, it was imperative that they were conducted in a sensitive and respectful manner.

**Taping of interviews**
Where the research participants agreed, the interviews were taped and all the tapes were transcribed. Around two thirds (63 interviews – 69%) of the interviews were taped. In the cases where the interview was not taped, some notes were taken during the interview and detailed case notes were written down immediately afterwards.

**Additional information**
Information obtained during the psychiatric assessment was also used to complement the data collected through the interviews. For all cases the case notes were supplemented with additional information obtained from the medical files.

**Ethics approval**
The project received formal ethical approval from the Western Sydney Area Health Ethics Committee and the University of Western Sydney, Ethics Review Committee (Human Subjects) in March 2000.

**Analysis**
The next section describes the process of data analysis and development of the coding framework used to organise and group the data collected in this study. Prior to describing the analytical process, the terms used in this study will be defined.

**Definition of terms**

**Grounded theory**
Grounded theory can be defined as a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon.

**Coding**
The term coding in this study is defined as the whole process of breaking interview data down into categories, which can be retrieved, reviewed and used in building theory about the phenomena under study.
In-vivo coding
In in-vivo coding (Strauss, 1987) the code is directly based on the actual words used by the participants.

Concepts and Categories
Minichiello and colleagues (1999) defined concept as “the basic units of analysis” and categories as “major concepts or groups of concepts that are useful in understanding or explaining the data” (p 590). A concept is the idea that a category or sub-category is based on. Category or sub-category includes:
- The idea (or concept);
- All the data about the idea; and
- The position the concept has in relation to all the other concepts.

The materials in this study were mainly managed using word processing and spreadsheet packages as well as SPSS.

Description of analysis
Because of the vast amount of information collected in this research the analysis was divided into four different stages. Different approaches to the analysis of the data were utilised in each of these stages. Stage 1 involved narrative structuring and meaning condensation of the data into individual analytical files. Stage 2 was a descriptive quantitative analysis utilising an SPSS data base. Stage 3 of this study involved a qualitative analysis of the motives and intentions expressed at the time of the event. Stage 4 of this study combined the data analysed in Stage 2 and 3. Figure 3.1 summarises this overall process.

Figure 3.1: Summary of stages utilised in analysis

<table>
<thead>
<tr>
<th>Stage 1:</th>
<th>Stage 2:</th>
<th>Stage 3:</th>
<th>Stage 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrative structuring and meaning condensation</td>
<td>Characteristics of sample</td>
<td>Circumstances of attempt</td>
<td>Identification of subgroups</td>
</tr>
<tr>
<td>Individual analysis of each of the participants</td>
<td>Quantitative analysis of risk factors</td>
<td>Qualitative analysis of intent</td>
<td>Combining risk factors with circumstances and motive of attempt.</td>
</tr>
</tbody>
</table>

The following is a detailed description of each these four stages.
Stage 1: Data Organisation and Narrative structuring

In this stage the vast amount of data collected for each participant was organised into a more manageable form. This organisation consisted of the following steps:

a) Transcription, narrative structuring and creation of reports;

b) Creation of analytical files; and

c) Creation of summary pages.

Whilst this stage was ostensibly about organisation it was none-the-less the first step in the analysis of the data. Even at the level of transcription decisions are made about the meaning of words and the emphasis given to certain parts of a narrative. While every attempt was made to be as true to the respondents meaning as possible, a degree of construction occurred by virtue of the process of interaction.

a) Transcription, narrative restructuring and creation of individual reports

The 63 taped interviews were transcribed$^6$ and the data collected from all 90 research interviews, psychiatric assessments and medical files were combined into comprehensive reports on each individual. As part of this step, the data was ‘cleaned’, making it more amenable to further analysis. This cleaning consisted of the elimination of digressions and repetitions from the case notes and transcripts in order to distinguish between the essential and non-essential.

As part of the process of writing the reports for each research participant a narrative structuring of each account was undertaken. This narrative structuring entailed a temporal and social organization of the text to bring out its meaning. This process was necessary as the final data set combined data from the psychiatric assessment undertaken by the psychiatric registrar with data from the research interview and so not all the information was collected in a linear fashion or was taped. The narrative structuring was also required because the mental state of the participants meant that their accounts were not told spontaneously, and so the researcher had to prompt for background information. Thus the narrative structuring can be seen as an attempt to create a coherent story out of the many happenings reported throughout the research and psychiatric interview.

As part of the narrative structuring a meaning condensation and interpretation of the events leading up to the attempt was also undertaken. This involved abridging the different motives expressed by the research participants into shorter formulations. For example, long statements were compressed so that the essence of what was

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$^6$ The majority of the tapes were transcribed by the researcher.
said was rephrased in a few words. These shorter formulations were then linked back to the original data.

The transcripts, case notes and reports were stored in spreadsheets to facilitate the manipulation of the data. In particular, the spreadsheets allowed the transcribed material to be coded in an ongoing manner. For example, codes could be applied to text of any length, from sentences to whole paragraphs and these codes could then be sorted. This, in turn, facilitated the identification of common connections and relationships between concepts. All the text was coded in this manner. This coded text was then either assigned to one of a number of developed categories or seen as an exception to these categories and examined to assess the challenge it offered to the developed categories. While not foolproof, this approach offered a degree of confidence that all data was considered and accounted for in any final set of findings (Minichiello et al 1999). All developed codes were also linked back to the original transcripts to establish a connection between the codes and the primary data.

In order to keep the study focussed the information was initially assigned to one of the following categories:

1. Mental health assessment;
2. Events leading up the attempt;
3. Family history;
4. Personal history;
5. Pre-morbid personality;
6. Previous medical history; and
7. Feelings at time of the interview and future hopes.

b) Creation of analytical files
The second stage in the organisation of the data involved the creation of analytical files for each research participant’s data. These analytical files consisted of the transcribed and restructured data as well as the data in a coded format.

This latter data was derived by coding the data that had been assigned to the seven categories described in the preceding section. Initially in-vivo coding (Strauss, 1987) was heavily used and the coding system was quite unstructured. After attaching the coding to the text of a number of documents, the codes became more abstract and

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7 Appendix 2 contains a more detailed description of these categories.
were grouped according to the statements that were used to describe their attempt. Through the process of detailed coding of the text, concepts and relationships were generated and these provided the basis of the analysis in Stage 3.

c) Creation of summary page

The information in the analytical files was further condensed into a summary page to facilitate data management (Minichiello et al, 1999). This page contained the following information:

- Interview details (location, how long after the event it occurred, whether it was performed in the presence of a psychiatrist, and quality of contact);
- Background information about the research participant (attempt method, age, gender, profession, psychiatric diagnosis, Axis I and II, social events);
- Family and behavioural background;
- A brief description of events;
- A brief description of the thought process;
- Motive for the attempt; and
- Concerns regarding the quality of the interview and the data.

The summary page facilitated the identification of sub groups and the development of subsequent codes and categories in Stage 3. The information condensed in this page was linked back to the original data (transcripts and case notes).

Thus it can be seen that Stage 1 consisted of the initial coding of the data. The codes and categories developed in this stage were further refined in Stage 3 and are reported on in Chapter 5. Note that the individual stories and codes developed in Stage 1 are not reported on in this thesis as these could be used to identify individual participants.

Stage 2: Descriptive quantitative analysis (SPSS)

During this stage, information collected through the interviews, psychiatric assessment and medical files were quantified. A questionnaire was constructed that contained items that were identified in the literature as having a significant impact on suicidal behaviour. The details of this questionnaire appear in Appendix 3. One hundred and two items were coded, ranging from demographic variables such as age and gender and data in regards to the physical characteristics of the attempt and previous attempts and psychiatric diagnosis (Axis 1 and 2, drug and/or alcohol abuse). Data also included the presence of social stressors prior to the attempt, and
behavioural characteristics of the research participants such as violent behaviour, general functioning throughout life as well as their family background (childhood experiences, history of abuse, parental mental illness).

The data was managed in an SPSS database. The primary analytical techniques employed to analyse and characterise this data were descriptive statistics such as means and frequency distributions, cross tabulations and chi-square/Fisher’s exact calculations of the categorical variables.

The results of Stage 2 are reported in Chapter 4.

**Stage 3: Qualitative analysis of motives and circumstances of attempt**

This stage focused on the motives and circumstances leading up to the attempt and involved a qualitative analysis of these motives. The analytic reports from Stage 1 formed the basis of this analysis.

At this stage of the analysis, the author had become thoroughly familiar with the data. This was because the author had performed all the interviews, transcribed most of the tapes and also reverified that the transcriptions accurately reflected the tape contents. The development of the case reports, the in-vivo coding and the writing of the analytical files and case summaries pages also aided familiarisation with the data.

Because of the complexity of the motives that are associated with a deliberate self-harm attempt, this stage was broken down into Phases 1 and 2. Phase 1 focussed on how participants had expressed the motives for the attempt. This involved the coding of the motives described by the participants and, through an inductive process, the development of these codes into categories. However the categories developed in Phase 1 highlighted conceptual difficulties associated with only focussing on motives alone. This necessitated the Phase 2 analysis which, while repeating the process undertaken in Phase 1, also incorporated the full description of the circumstances of the self-harm event.

**Phase 1**

This phase focussed on the research participants’ motives and the way they verbalised these. For this analysis the accounts of the participants were scrutinised and coded for content and meaning. The individual reports and analytical files created in Stage 1 of the analysis provided the basis for this phase. The techniques used for coded were similar to those described in Stage 1 of the analysis. However

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8 The conceptual difficulties of this analysis are described in Chapter 5
they differed in that Phase 1 focussed on finding categories that were relevant across cases. This was done by coding each individual attempt motive and where words described a similar type of motivation (for example as “anger”) these were given similar codes and then combined into a category (for example “attempt made out of anger”). The categories were derived inductively.

Chapter 5 provides a breakdown of the motivations for the attempts, as they were categorised in Phase 1.

**Phase 2**
In this phase the categories developed in Phase 1 were further developed. The dimensions selected as significant in Stage 2 were selected and included into the qualitative analysis. The dimensions used to further categorise the motives included:⁹

- The types of problems/situations described and triggering events;
- Whether these problems were chronic (longstanding) or acute (pivotal) – these were drawn on the findings from the qualitative analysis in Stage 2;
- Persistence of thoughts of self-harm (impulsive or non impulsive); and
- The presence or absence of these feelings at the time of the interview (the resolution of the attempt).

This resulted in the development of subcategories. The categories developed in Phase 2, were then tested against the original data. The 90 cases in this study were subjected to classification by an expert panel composed of a clinical psychologist and a social worker with clinical and research experience in depression. The panel were asked to place each of the 90 cases into one of the developed categories. The individual reports and analytical files developed in Stage 1 of this analysis were used for this classification. The categories developed are reported in the second part of Chapter 5.

**Stage 4: Description of identified groups**
This stage described the categories developed in Phase 2. Once all the cases were categorised according to the above coding framework, the data was subjected to one final layer of analysis. This analysis reintroduced the quantitative data from Stage 2 but also included the presence or absence of known risk factors. This was done by entering the classified cases into the SPSS data base and then cross tabulating them with the following:

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⁹ The detailed results of this analysis are reported in Chapter 5.
• Social and demographic factors (age, gender, socio-economic status, educational achievement);

• Family characteristics and childhood experiences (parental mental health problems, discord, parental loss, parental care characteristics, abusive experiences, other family problems);

• Environmental factors (life events, behaviour characteristics such as violent behaviour and precipitating factors to attempt); and

• Mental health/illness problems (mental health problems, mental illness, harmful drug use, previous suicide attempts, previous psychiatric care).

The narrative summaries were then arranged according to the identified categories. By taking the findings back to the file transcripts, words of the research participants were used to further describe the categories.

These groups are described in detail in Chapters 6 and 7.

Validity and reliability of the data collected
Minichiello and colleagues (1999) state that qualitative research is more difficult to evaluate. They state:

“The criteria by which to distinguish between good and poor research in qualitative research are more difficult to specify, because there is no general agreement among researchers what they should be. It should be helpful at this point if we briefly consider some of the assumptions which underlie qualitative research. Firstly most qualitative researchers do not believe that it is possible to be objective […]. Secondly, qualitative researchers believe that reality is socially constructed and is constantly being reconstructed so that it changes over time and varies according to local circumstances.” (Minichiello et al, 1999, p 41)

The issue of validity, in the sense of an accurate understanding and representation of what is being investigated, has concerned many authors. Different techniques have been developed which attempt to enhance trustworthiness, credibility, dependability, confirmability, authenticity (or validity) of qualitative research. These include: methodological procedures such as careful sampling, procedures and preparation of field notes or transcripts, contextualisation, triangulation, reflexivity, the presentation of evidence in the form of quotes or incidents from informants’ lives to support conclusions (Minichiello et al, 1999).
Most of the techniques, as they are described by Minichiello and his colleagues, were used in this study, these were described in detail above. However it is appropriate at this stage to express some caution about the data collected and analysed in this study. In the next section some of the weaknesses of this study will be discussed. Those that will be discussed are: 1) limitations in regards to missing information; 2) primary and secondary data; 3) being part of a psychiatric assessment team; 4) the reconstruction of feelings after the event; 5) the impact of the emotions on the mental state and motives expressed; and 5) not admitting to the real motive of the attempt.

1: Missing information
Conducting a research interview whilst people are still in crisis and under medical care is not without difficulties. Some of these difficulties included issues such as tiredness of the research participants, interruptions by the treating medical staff, and families’ and the patients’ eagerness to leave the hospital. Because of these practical limitations, at times only partial histories were taken. All efforts were made to minimise the amount of missing information; however in certain cases this was unavoidable. It is important to emphasise at this point that the research had to fit in with the treatment offered at the hospital and the life circumstances of the participants. The first concern was always the well being of the participants. With this type of research these issues cannot be avoided. Where information was missing this was stated in the discussion and analysis.

2: Primary and secondary data
In this research, the final data used in the analysis could come from different sources as part of the information was collected through the psychiatric interview, the research interview, notes taken during and after the interview and information taken from the medical files. The following processes minimised the impact of this. Firstly the majority of the information was collected first hand, and the medical files were mainly used to collect ‘factual’ data such as dates of previous admissions, methods used in previous attempts, and stated motives; secondly the medical files were read prior to the interview and during the interviews this information was confirmed with the research participants; Finally the interviewer was present during the psychiatric interviews and she had first hand knowledge of the accounts provided by the participants. When she was not present in the psychiatric interview she was able to collect the information first hand.

It is important to note that in the large majority of the cases, the data collected by different sources was not dissimilar. However in case of where there was a
discrepancy between two different sources, as this research had a main focus on how participants explained their attempt, the participants’ version was taken as the most appropriate and a note was made about the discrepancy of the accounts. It is the author’s belief that the collection of the data from different sources increased, rather than decreased, the quality of the data.

However of more concern was that in this research not all the interviews were taped and/or, at times the motive of the attempt was discussed prior to the start of the recording. Depending on the mental state of the research participants at times, it was inappropriate for the research participant to have to repeat the motive for the sake of the tape. In these cases the interviewer would summarise the motive to the participants in order to make sure that the meaning was fully understood; However this meant that the actual intent was not expressed in the words of the participants. Below is an extract of an interview to illustrate this:

RP 32: 41 year old female who had taken an impulsive overdose in reaction to a minor social stressor.

Interviewer: You are feeling, this is what I understand, you tell me if I am wrong. I understand that you are feeling almost in two minds. You are feeling very down, and you feel that it is very difficult for you at the moment with all this stuff going on. But you still have this part in you that is quite strong and that you want to live it and that it is this continual battle that is going on and yesterday one of them took over. So today you’re feeling sad but the other one is not taking over.

RP: That is right, spot on.

The fact that the data collected could come from different sources and that not all the information was on tape made the traditional theme analysis by quotes more difficult. Different procedures, such as the writing of case notes straight after the interview, inclusion of information from the psychiatric assessment, continual checking with the participants of the actual intent were set in place to minimise the impact of these factors on the data collected. It did mean however that primary (interview transcripts) and secondary (case notes) data were used in this study. This had particular relevance for Stage 3 of the analysis, where the intent of the self harm attempt was analysed and had the potential to introduce a bias into the data collected. In order to avoid this bias the words of the participants are used as much as possible to describe the different identified groups.
3: Being part of the psychiatric team

The fact that the researcher was part of the liaison psychiatry assessment team had advantages as well as limitations in collecting the data for this research. The advantages included 1) reduced strain for the research participants; 2) assessment if attempt was deliberate or accidental; 3) assessment of cognitive ability of participants; 4) ability for research participants to further explore their feelings in regards to the attempt and; 5) the collection of psychiatric data.

Reduced strain for the research participants
People who have tried to harm themselves are in a vulnerable state and are often tired from their experience. The fact that the researcher was part of the psychiatric assessment meant that the research participants did not need to unnecessarily repeat their stories to the researcher. It is also possible that the sample size was increased because of this.

Assessment if attempt was deliberate or accidental
The fact that the researcher sat in on the actual assessment allowed for the researcher to determine whether or not the attempt was deliberate or accidental.

Assessment of cognitive ability of participants
By sitting in on the psychiatric assessment the researcher was able to assess the cognitive abilities of research participants and their ability to give informed consent.

Ability for patients to further explore their feelings
As noted earlier, people who have made an attempt to harm themselves have a need to discuss their attempt (Treatment Protocol Project, 1997). In the context of a busy hospital where there are a lot of time demands on the registrars, having a researcher who has more time to explore some of the issues with people who have attempted to harm themselves can be beneficial for the patients.

The psychiatric assessment followed by a research interview further exploring issues associated with an attempt can have a positive impact on the participants. It was not the purpose of this research to investigate the impact of the research interview on the mental state of the research participants. However it is important to note that, for a large number of people, the interview appeared to have a positive impact on their mental state. Many people who participated in this study thanked the interviewer for listening to their stories. Below are two extracts of interviews where the participants talk explicitly about the value of being able to talk to someone about their feelings.
RP 73: 46 year old female who had taken an overdose because there were too many stressors around her. She felt that talking about what she had gone through had helped her put things in perspective.

RP: [It] Made me feel better to talk [about] what it did to, you know, to talk to somebody.

Interviewer: Was it because it helped you put it in perspective again?

RP: Yeah. […] It’s a very frightening experience. You don’t realise just how much, how frightened you are, until it’s all over and done with. […]

Interviewer: I’m actually finished. Thank you very much for talking to me.

RP: That’s alright. Thank you. […] I appreciate the talk, don’t worry.

RP 11: 42 year old female who tried to overdose in the emergency department when she woke up after a grand mal fit.

Interviewer: I think that is it for me. We’ve covered everything.

RP: That was pretty painless, I quite enjoyed it actually like, yeah I did. I feel a lot better. […] because venting and verbalising really, and with J___ [partner] it is always about J___ you know and you never get a chance. And like I said we used to do it, and we just got into the routine of just - […] like you said before about counselling, and I am willing to give it a go, you know. I thought about it since the other day and I thought about it this morning. Like, first I thought “oh no, can I go back through it all again?” And now that I have been talking I feel quite good about it.

This positive effect was not noted in all of the research interviews and it would be unrealistic to expect this effect in a study such as this. However these examples show the importance of talking about the deliberate self-harm attempt in detail.

Collection of psychiatric data

Being part of the Liaison Psychiatry Team also allowed for the collection of detailed psychiatric data. This enhanced the data collected through the interviews. In addition it enabled the researcher to refer the participants back to the psychiatric team when additional issues were raised throughout the research interview that had important
bearing on the participant’s treatment. This occurred in four interviews, and in these cases permission was sought from the participant to relate the information back to the psychiatric assessment team.

There were also a number of disadvantages and although these are small in number, they should be noted here. These included 1) change of dynamics and; 2) being perceived as a staff member.

**Change of dynamics:**
The fact that the author was integrated within the assessment team had the potential to change some of the research dynamics. The research interview was often performed straight after the psychiatric interviews which, at times, made it difficult to revisit the events from a slightly different perspective. In addition as discussed above this meant that, at times, the motive of the attempt was discussed prior to the start of the recording, which made a traditional theme analysis more difficult as not all the quotes were taped and part of the intent was discussed off tape.

**Being perceived as a staff member**
In order to gain access to the research participants it was necessary for the researcher to wear a hospital identification badge. The researcher was thus generally seen as being part of the treating team. This may have interfered with the decision to participate, as the patients may have felt under greater obligation to cooperate, or that association with the assessment team may have made them less inclined to do so. Notwithstanding these concerns, it has to be noted that all efforts were made to make sure that the participants understood the difference between the researcher and the treatment team and to appreciate that the aims of the research interview were different. A number of people who were in conflict with the psychiatrist did agree to participate in the research and talked about their concerns with their psychiatric treatment to the interviewer.

It remains difficult to evaluate what the impact was of being integrated within the research team, but it is the author’s opinion that the benefits far outweighed the disadvantages.

**4: Reconstruction of state of mind after the event**
This research aimed to reconstruct the state of mind of people who attempted to harm themselves. This aim is not without difficulties. The difficulties that will be discussed include: 1) impact of time on mental state and reconstruction of motive and; 2) not admitting to real motive of attempt.
5: Impact of emotions on mental state and motives expressed

The interviews were performed as soon as possible after the attempt, but the emotions associated with the attempt had often disappeared at the time of the interview. This was likely to have had an impact on the account provided to the interviewer. This is because the emotional state in which people find themselves at the time of the interview is likely to influence the motive of the attempt. When the emotions have calmed down, the described motives for the attempt can change. Below are three examples of cases where this occurred.

RP 44, 24 year old female:
She presented to the emergency department with a slit wrist. She had attempted to harm herself after a fight with her step-father. By chance the researcher was present in the emergency department when she was admitted and had noted in her file that the participants presented as tearful and depressed. She was crying and stated to the researcher that she was feeling depressed. She could not be formally interviewed at that time as it was necessary for her to undergo surgery. She was interviewed the next day on the psychiatric ward and presented very differently. She felt calm and composed and stated that she did not feel depressed. She stated that she had made her attempt because she was angry and hurt. She denied that she had been feeling depressed the day prior. It is possible that if she had been interviewed at the time she was admitted, she would have given a different account of her motive and the “mental state” she was in whilst she attempted.

RP 26, 42 year old male. He was brought to the attention of the emergency department after he had taken an overdose. He did not have any severe medical consequences of the overdose and was able to be interviewed shortly after his admission to the emergency department. During the psychiatric interview he presented as being depressed and stated that he wanted to die. He was scheduled to be admitted to the psychiatric hospital for further observation. The research interview was performed straight after the psychiatric interview and lasted for 2 hours. During this time, the research participant was calming down and stated that the motive for his attempt was to make his wife realise how her behaviour affected him. He stated that he did not want to die anymore. That night he was reassessed by the admissions officer of the psychiatric hospital and was released home. If this man was interviewed the next day it is possible that he would not have included the notion of
death into the motives of his account and would not have presented as depressed.

RP 96: 38 year old female. In the medical notes it was noted that when she was admitted to the emergency department the night prior, she stated that she wanted to die on different occasions. She was drunk at the time. At the time of the interview less than 12 hours later, she denied that she had wanted to die. She was unable however to describe her motives and stated that she was too drunk to remember what she intended to do.

What these cases illustrate is the confused feelings that are associated with making a deliberate self harm attempt and that the expressed motives of the attempt can change according to the mental state when they are interviewed. At times the notion of death appears to be present at the early phase of the suicidal state, but this can change over time, when the emotions associated with the attempt are less strong. It is possible the meaning associated with the attempt will again change over time after patients have had the time to reflect on their actions and integrate their attempt into their lives. It is possible that they will give a different account of their motives in a few months time. This poses theoretical difficulties in particular in relation to the data analysed in Phase 1 of Stage 3 in this study. For practical and ethical reasons, it was not possible to interview them during the crisis or just after. Thus the accounts that are provided by people who attempted to harm themselves are a recollection of the attempt and might not always necessarily reflect the actual emotional state at the time of the interview. This had an effect on the accounts of the motives they associated with the attempt.

6: Not admitting to real motive of the attempt

Another difficulty in a study that investigates the motives of the attempt lies in the fact that research participants are not always admitting to the true motives of their attempt. This can be because of different reasons. It is possible that some motives described are seen as being more socially acceptable. Certain participants might not have wanted to admit to the true motives as either they wished to be admitted to the psychiatric ward or wanted to be released from hospital. They might have feared that admitting to the true motives of their attempt would not allow this. Below are a few examples of where the interviewer had been aware of these situations. It is possible that this has also occurred with other participants and this may have escaped the notice of the author.
RP 90: 57 year old female. She had taken a large overdose. She had been feeling depressed for quite some time. She was very religious and considered suicide to be a sin. She denied that she had wanted to die and denied that she was feeling suicidal at the time of the interview. She stated that she was uncertain what she had intended when she had taken the overdose. It is likely that her answers were influenced by her religious beliefs. It was the researcher’s and treating registrar’s belief that she intended to die.

RP 75: 32 year old male. He stated that he had taken a large overdose on his medication however he did not have any associated physical symptoms. He described the attempt and the low feelings he was experiencing as being associated with this medical condition. In the medical files it was however noted that he did not have this medical condition. The interview was very convoluted and he contradicted himself on different occasions. Throughout the interview he did give hints in regards to other motives, but was unwilling to elaborate on any other explanation than the one he had given.

RP 18: 24 year old male, he had tried to hang himself during a fight with his wife. At the time of the interview, he was pacing the emergency department and wanted to leave. He did not understand why he had to have a psychiatric assessment and denied that he had any suicidal intent and stated that he was just “mucking around.” In the medical files it was noted that he had expressed a wish to die to the admitting nurse the night prior. At the time of the interview, he was unwilling to consider the risks he had taken and was eager to be released from the hospital. He stated that he did not have any issues and would not attempt to harm himself again.

RP 65: 59 year old male, he had stabbed himself in the chest. He attempted in the midst of a fight with his partner, he stated that he did not really remember what went through his mind at the time of the attempt. It is possible that the shock influenced his memory, however he was facing sexual assault charges at the time of the attempt and it is likely that he did not want to talk about the true motives to the researcher and registrar.

How truthful the participants were during the interviews was largely related to the rapport that established with the interviewer. However no matter how much efforts
were made to establish a good rapport, it is unrealistic to expect that all research participants will tell the true motives of the attempt. Initially the author assumed that the research participants were telling the truth. However when she had her doubts, she would use her clinical judgement and would discuss these cases with the treating registrars in regard to the truthfulness of the accounts provided. The doubts voiced by the author were included into the analytical files and included into the final analysis. It is important to note however that these situations were relatively rare and that the large majority of the participants did want help in regards to their problems and were most likely being truthful in regards to the motives expressed.

Summary

This study used quantitative as well as qualitative methods to collect and analyse data on a range of aspects of deliberate self harming behaviour of 90 people who had had come to the attention of the Accident and Emergency Department of Westmead Hospital. 4 stages of analysis were undertaken in this study. Stage 1 involved narrative structuring and meaning condensation of the data into individual analytical files. Stage 2 was a descriptive quantitative analysis utilising an SPSS database. Stage 3 of this study focussed on a qualitative analysis of the motives and intentions expressed at the time of the event. Stage 4 of this study combined the data analysed in Stage 2 and 3.

The participation rate in this study was high and the data collection was conducted over a 13 month period (including week ends) which allowed for the inclusion of a wide variety of presentations and accommodation of seasonal variation and over 65% of the participants allowed for the research interview to be taped.

A number of weaknesses in regards to the data collected were identified. These included: 1) limitations in regards to missing information; 2) inclusion of primary and secondary data; 3) being part of a psychiatric assessment team and; 4) the difficulties in reconstructing the state of mind after the event.
Chapter 4: Stage 2 – Sample Characteristics

This chapter reports on Stage 2, the quantitative data and provides an overview of the characteristics and risk factors of all the research participants. The data is presented in the following categories: 1) demographic characteristics; 2) characteristics of the attempt; 3) characteristics of previous attempts; 4) psychiatric diagnoses; 5) social stressors; 6) behavioural background; and 7) family characteristics and childhood experiences. All the statistics are based on 90 cases. The percentages have been rounded to the nearest integer and therefore may not add up to 100. The analysis and statistics were performed using the SPSS statistical software package.

Demographics characteristics

The following section describes the social and demographic factors of the participants in this study. Table 4.1 and 4.2 shows the age and gender of the respondents in the study.

Age and gender

Table 4.1: Age of study participants

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>18 to 24</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>25 to 34</td>
<td>23</td>
<td>26</td>
</tr>
<tr>
<td>35 to 44</td>
<td>23</td>
<td>26</td>
</tr>
<tr>
<td>45 to 54</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>55 to 64</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>65 +</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

As noted in the Chapter 3, Stage 1 will not be reported on.
Table 4.2 Gender

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>37</td>
<td>41</td>
</tr>
<tr>
<td>Females</td>
<td>53</td>
<td>59</td>
</tr>
</tbody>
</table>

It is evident that the majority of the people in the sample are under the age of 45 years and there were more females than males in this sample (59% compared to 41%).

Relationship status

Table 4.3 describes changes in relationship status in the month prior to the attempt.

Table 4.3: Changes in relationship status

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>In relationship 1 month prior to attempt</td>
<td>51 (57%)</td>
<td>39 (43%)</td>
</tr>
<tr>
<td>In relationship time attempt</td>
<td>28 (31%)</td>
<td>62 (69%)</td>
</tr>
</tbody>
</table>

It can be seen that more than half of this sample (57%) was in a relationship one month prior to the attempt; however this number dropped to only a third of the sample (31%) at the time of the attempt.

Occupation

Table 4.4 shows the occupation of the study participants at the time of the event.

Table 4.4: Occupation of study participants

<table>
<thead>
<tr>
<th>Occupation</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Blue collar</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>White collar</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>Home duties</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Student</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Unemployed</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Retired</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Disability pension - sickness benefits</td>
<td>34</td>
<td>39</td>
</tr>
<tr>
<td>Prison</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
It is evidenced here that there are a small number of professionals and white-collar workers (23%) and the relatively large number of people who are on a disability pension/sickness benefits or unemployed (49%).

**Cultural and linguistic diversity and Indigenous background**

One fifth of the sample is from a Cultural and Linguistically Diverse background while Seven percent (n=6) described themselves as indigenous.

**Children of participants and their ages**

Tables 4.5 and 4.6 report on the children of the participants and their ages.

**Table 4.5: Participants with children**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Children</td>
<td>46</td>
<td>52</td>
</tr>
<tr>
<td>Children</td>
<td>44</td>
<td>48</td>
</tr>
<tr>
<td>Children in care</td>
<td>16</td>
<td>18</td>
</tr>
</tbody>
</table>

**Table 4.6: Age of participants’ children**

<table>
<thead>
<tr>
<th>Age children</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under age of 10</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>10 to 18</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Over 18</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>No children</td>
<td>46</td>
<td>52</td>
</tr>
</tbody>
</table>

It can be seen from table 4.5 that almost half of the sample (48%) has children. Furthermore table 4.6 reveals that of those with children that 32% were under the age of 18 and 21% of the children were under the age of 10. It is of particular concern that one third (36%) of the children were in the care of the participant at the time of the attempt.
**Characteristics of the attempt**

This section will report on the characteristics of the attempt. Tables 4.7 to 4.9 report on the methods utilised in the deliberate self harm attempt.

**Method**

Table 4.7 summarises the method of attempt used by the research participants.

<table>
<thead>
<tr>
<th>Method</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overdose</td>
<td>67</td>
<td>74</td>
</tr>
<tr>
<td>Cutting</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Hanging</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Stabbing</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Jumping</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Car exhaust</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Drowning</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Shooting</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

From table 4.7 it is evident that the majority of the sample (74%) had tried to harm themselves by taking an overdose.

Table 4.8 shows a breakdown of the substances that were used in the overdose attempts by the participants.

<table>
<thead>
<tr>
<th>Type of Overdose</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric medication</td>
<td>32</td>
<td>36</td>
</tr>
<tr>
<td>Other medication</td>
<td>29</td>
<td>32</td>
</tr>
<tr>
<td>Overdose and cutting</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Heroin</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Overdose and drowning</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

It is clear that the majority of the overdoses were either with psychiatric or other medication. Only four percent used a combination of methods.
Gender and method
Table 4.9 reports on the methods utilised by gender.

Table 4.9: Method of attempt by gender

<table>
<thead>
<tr>
<th></th>
<th>Overdose</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>20 (54%)</td>
<td>17 (46%)</td>
<td>37 (100%)</td>
</tr>
<tr>
<td>Females</td>
<td>48 (91%)</td>
<td>5 (9%)</td>
<td>53 (100%)</td>
</tr>
</tbody>
</table>

P ≤.0001, df=1

Ninety one percent of the females (compared to 54% percent of the males) in this sample had overdosed. These findings were statistically significant (p ≤.0001, df=1).

Physical consequences
Table 4.10 describes the physical consequences of the attempt

Table 4.10: physical consequences of attempt

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of consciousness</td>
<td>22</td>
<td>36</td>
</tr>
<tr>
<td>Admitted to Intensive care unit</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Lasting physical impairment</td>
<td>12</td>
<td>13</td>
</tr>
</tbody>
</table>

It is apparent from table 4.10 that all of the attempts that resulted in an admission to the emergency department included in this sample required some type of medical attention. Thirty six percent of this sample lost consciousness while 17% were admitted to the Intensive Care Unit. Thirteen percent were left with lasting physical impairment as a consequence of their attempt.

Attempt under influence of alcohol
Table 4.11 reports on the proportion of males and females under the influence at the time of the attempt. These figures do not take into account those participants who reported drinking for courage.
Table 4.11: Proportion of participants under the influence during the attempt by gender

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under influence</td>
<td>19 (66%)</td>
<td>10 (34%)</td>
<td>29 (100%)</td>
</tr>
<tr>
<td>Not under influence</td>
<td>18 (30%)</td>
<td>43 (70%)</td>
<td>61 (100%)</td>
</tr>
</tbody>
</table>

Pearson Chi-square p ≤.001, df=1

One third (n=29, 32%) of the participants had their judgement impaired by alcohol when they attempted to harm themselves. Sixty six percent of the sample who attempted under the influence were male (compared to 34% of females) (p ≤.001, df=1).

Timing of suicidal thoughts

Table 4.12 reports on the participants’ estimates of the length of time they had thought of harming themselves and the actual act of self harm. It does not account for any fleeting suicidal thought that might have been present in the weeks leading up to the attempt.

Table 4.12: Time between suicidal thoughts and action

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 5 minutes</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>5 to 9 minutes</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>10 to 19 minutes</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>20 to 29 minutes</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>30 to 59 minutes</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>1 to 6 hours</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>6 to 24 hours</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>More than 24 hours</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

The timing of the actual suicide attempt varies greatly for the participants in this sample. For a large number of participants in this study the self harm attempt was very impulsive. Half of this sample (51%) had thought about harming themselves for less than 10 minutes before acting on this thought. An additional 16% thought about it for less than 30 minutes.
Impulsiveness and alcohol

Table 4.13 reports on the association between impulsiveness and presence of alcohol\textsuperscript{11} at the time of the event.

\textbf{Table 4.13: Association between impulsiveness and alcohol intake}

<table>
<thead>
<tr>
<th></th>
<th>&lt; 10 minutes</th>
<th>&gt; 10 minutes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the influence of alcohol</td>
<td>26 (93%)</td>
<td>3 (7%)</td>
<td>29 (100%)</td>
</tr>
<tr>
<td>Not under the influence of alcohol</td>
<td>34 (55%)</td>
<td>28 (45%)</td>
<td>61 (100%)</td>
</tr>
</tbody>
</table>

Fisher’s exact $p \leq 0.0001$, df=1

As this table shows, when cross-tabulating the length of suicidal thoughts with whether or not the attempt was done under the influence of alcohol, it can be seen that 93% of those who were under the influence of alcohol thought about their attempt for less than 10 minutes compared to 55% of those who were not under the influence. The association between impulsiveness and being under the influence of alcohol was found to be statistically significant ($P<0.0001$, df=1).

Post event mental state (PEMS)

Table 4.14 reports on the proportion of respondents whose mindset had changed between the time of the attempt and the time of the interview.

\textbf{Table 4.14: Respondents’ state of mind at time of interview}

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Similar to time of attempt</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>Similar (but no impulse to harm oneself)</td>
<td>30</td>
<td>33</td>
</tr>
<tr>
<td>Shift of mindset</td>
<td>41</td>
<td>46</td>
</tr>
</tbody>
</table>

There were marked differences in the state of mind people were in at the time of the interview. Only one fifth (21%) of this sample was still feeling suicidal at the time of the interview. The suicidal impulse had disappeared for four fifths (79%). However, one third (33%) of the people in this sample still experienced similar feelings to those prior to the attempt but the impulse to harm themselves had disappeared. Even more striking is the fact that for almost half of this group (46%) there was a marked shift in their mental state, as they were either able to problem-solve about their situation or were calm about the issues they experienced leading up to the attempt.

\textsuperscript{11} These statistics do not include drinking for courage
**Being sober**

Table 4.15 compares those who had their judgment impaired through alcohol with those who reported they were not acting under the influence.

**Table 4.15: Association between being under the influence of alcohol during the attempt and the PEMS**

<table>
<thead>
<tr>
<th>State of mind at time of the interview</th>
<th>Similar</th>
<th>Similar (no impulse)</th>
<th>Shift of mindset</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under influence</td>
<td>1 (4%)</td>
<td>7 (25%)</td>
<td>20 (72%)</td>
<td>28 (100%)</td>
</tr>
<tr>
<td>Not under influence</td>
<td>18 (29%)</td>
<td>23 (37%)</td>
<td>21 (34%)</td>
<td>62</td>
</tr>
</tbody>
</table>

Pearson Chi-Square $p \leq .002$, $df=2$

As table 4.15 reports, striking differences can be seen. The association between being under the influence and change in mindset was found to be significant ($p < .002$, $df=2$) Three quarters (71%) of those who attempted under the influence of alcohol had a marked shift in their state of mind the next morning compared to one third (34%) of those who did not attempt under the influence. The situation was perceived very differently for participants who were sobering up.

**Admission to psychiatric ward**

Table 4.16 reports on the admission status of the participants

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to psychiatric ward</td>
<td>31</td>
<td>35</td>
</tr>
<tr>
<td>Discharged</td>
<td>49</td>
<td>55</td>
</tr>
</tbody>
</table>

One third (35%) of this sample were still actively suicidal or mentally disordered at the time of the psychiatric assessment and were admitted to the psychiatric ward. Two thirds (65%) were discharged to the care of their family or friends and were given a follow-up appointment with the community mental health team.

**Previous attempts**

The following section reports on previous attempts that were made by the people in this sample.
**Previous attempts**
Two thirds (70%) of this group had attempted to harm themselves in the past. Table 4.17 summarises the time between the last attempt and the index attempt (the attempt that brought them to the hospital).

**Table 4.17: Time between last attempt and index attempt**

<table>
<thead>
<tr>
<th>Time</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one week</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>1 week to 1 month</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>1 to 3 months</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>3 to 6 months</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>No previous attempts</td>
<td>27</td>
<td>30</td>
</tr>
</tbody>
</table>

Fifty percent of the sample (71% of those who have attempted in the past) made a previous attempt within the six months prior to the index attempt. Only 14% of this group had attempted more than one year prior to their index attempt.

**Number of previous attempts**
Table 4.18 reports on the number of previous attempts made by the participants.

**Table 4.18: Number of previous attempts by participants**

<table>
<thead>
<tr>
<th>Number</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>2 to 4</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>5 or more</td>
<td>31</td>
<td>34</td>
</tr>
<tr>
<td>No previous attempts</td>
<td>27</td>
<td>30</td>
</tr>
</tbody>
</table>

There are different patterns of previous attempts in this sample. One third (34%) of this sample (half of those who have attempted in the past) had made more than five previous deliberate self harm attempts. A little less than one fifth (18%) of this sample had made one previous attempt.
Patterns of previous attempts
Table 4.19 reports on the patterns of previous attempts.

<table>
<thead>
<tr>
<th>Pattern of previous attempts</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous attempt when in similar crisis</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>Repeatedly throughout life</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Only when having an episode of mental illness</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>No attempts prior to current crisis</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>One attempt in distant past (&gt; 10 years)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>No previous attempts</td>
<td>27</td>
<td>30</td>
</tr>
</tbody>
</table>

Participants, who had made previous deliberate self harm attempts in the past, did so when they were presented with similar circumstances. Only three participants (3%) described the circumstances of their previous attempt as different from the current attempt. One quarter of this sample (24%) described a pattern of repeated attempts throughout their lives. One fifth (21%) stated that their previous attempts were made when they were in a similar crisis, and 10% stated that they only attempted to harm themselves whilst experiencing an episode of mental illness. For 9% of this sample the deliberate self harming behaviour had only started recently. They stated that they had not made any attempts prior to the current crisis.

Psychiatric diagnoses
This section reports on the psychiatric diagnoses given to the people in this sample. These include Axis 1, Axis 2 and drug and/or alcohol abuse. The Diagnostic and Statistical Manual IV TR (American Psychiatric Association, 2000) classification of mental disorders is multi-axial. The Axes 1 and 2 comprise the classification of abnormal behaviour. The Axis 1 includes all categories except for the personality and specific developmental disorders, which make up the axis 2. The Axis 1 and 2 were separated to make sure that that presence of long term disturbances are considered in the diagnostic process (Davison, 2001)\textsuperscript{12}.

\textsuperscript{12} From this point onwards the psychiatric illness/mental illness will be utilised interchangeably for the Axis 1 diagnoses and personality disorder for the Axis 2 diagnoses.
Diagnosis
Tables 4.20 reports on the different diagnoses that were given to the participants by the treating psychiatric team.

Table 4.20: Proportion of participants with a mental illness, by diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive disorder</td>
<td>66</td>
<td>73</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder (PTSD)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>No Axis 1</td>
<td>14</td>
<td>16</td>
</tr>
</tbody>
</table>

Eighty five percent of the people in the sample were diagnosed with a mental illness by the treating psychiatrists. The diagnoses given were mainly depression (73%) and psychotic disorders (11%).

Depression
Table 4.21 gives a detailed breakdown of the different types of depression.

Table 4.21: Participants diagnosed with depression, by type of depression

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment disorder with depressed mood</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>Depression not otherwise specified</td>
<td>23</td>
<td>26</td>
</tr>
<tr>
<td>Major depression</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Dysthymia/melancholic depression</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Paranoid depression</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Major depression ddx(^{14}) schizophrenia</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Partially treated major depression</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Heroin induced mood disorder</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bi-polar depressed phase</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bi-polar – manic phase</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Postnatal depression</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No depressive disorder</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>No Axis 1</td>
<td>14</td>
<td>16</td>
</tr>
</tbody>
</table>

\(^{13}\) Does not add up to 100 because of co-morbidity in some diagnoses

\(^{14}\) Ddx: differential diagnosis
As table 4.21 shows, a variety of types of depression are present in this study. The main diagnosis were adjustment disorder with depressed mood (27%), depression not otherwise specified (26%) and major depression (7%).

**Psychotic disorder**
In this sample 10 % were diagnosed with a psychotic disorder (8% were diagnosed with schizophrenia and 2% were diagnosed with drug induced psychosis. These figures need to be interpreted with caution because people who were too psychotic at the time of the interview were excluded. This has been discussed in Chapter 3.

**Anxiety disorder**
Around one tenth (9%) of this sample were diagnosed with anxiety disorder (see table 4.20).

**Personality disorders**
Tables 4.22 report on the proportions of people who have been diagnosed with a personality disorder.

**Table 4.22: Proportion of participants with a personality disorder by diagnoses**

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline</td>
<td>21</td>
<td>23</td>
</tr>
<tr>
<td>Antisocial</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Dependent</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>No Axis 2</td>
<td>49</td>
<td>53</td>
</tr>
</tbody>
</table>

Almost half of this sample (46.5%) were diagnosed with a personality disorder. These are mainly borderline (23%), anti-social (11%) and dependent personality disorder (9%).

**Drug and alcohol abuse**
The next section will report on the proportion of participants who were diagnosed with drug and alcohol abuse. Tables 4.33 and 4.34 report on the proportion of participants with a diagnosis of drug and alcohol, by gender and by substance.
Table 4.23: Proportion of participants with diagnosis of drug and/or alcohol abuse, by gender

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug and/or Alcohol abuse</td>
<td>48</td>
<td>28 (31%)</td>
<td>20 (22%)</td>
</tr>
<tr>
<td>No Drug and/or Alcohol abuse</td>
<td>42</td>
<td>9  (10%)</td>
<td>33 (37%)</td>
</tr>
</tbody>
</table>

Chi square p ≤.0001, df=1

Table 4.24: Proportion of participants with diagnosis of drug and alcohol abuse by substance *

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>40</td>
<td>44</td>
</tr>
<tr>
<td>Marijuana</td>
<td>33</td>
<td>37</td>
</tr>
<tr>
<td>Speed/heroin</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Prescription medicine</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Methadone</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>No D and A abuse</td>
<td>42</td>
<td>47</td>
</tr>
</tbody>
</table>

As table 4.23 shows, half (53%) of this sample had been diagnosed with drug or alcohol abuse. Table 4.24 gives a detail of the different drugs used. The majority of this sample used a combination of drugs (mainly alcohol and marijuana). Forty four percent identified as abusing alcohol. Table 4.23 also shows that males were more likely than females to abuse drugs in this sample. Thirty one percent of the men were diagnosed with drug and alcohol abuse being males compared to 22% of the women. This association was found to be statistically significant (p ≤.0001, df=1)

**Social stressors**

Tables 4.25 to 4.27 report on the presence of significant social stressors (as identified by the participants) prior to the attempt.

Table 4.25: Participants with social stressor(s) prior to attempt

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social stressor(s)</td>
<td>75</td>
<td>83</td>
</tr>
<tr>
<td>No social stressor</td>
<td>15</td>
<td>17</td>
</tr>
</tbody>
</table>

* Percentages do not add up to 100% because some participants abused more than one drug.
Table 4.26: Participants with social stressor(s) prior to the attempt by type of stressor

<table>
<thead>
<tr>
<th>Stressor</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship difficulties</td>
<td>39</td>
<td>43</td>
</tr>
<tr>
<td>Family problems</td>
<td>29</td>
<td>32</td>
</tr>
<tr>
<td>Housing issues</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>Legal problems</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Financial problems</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>Difficulties with children</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>Loss of employment</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Health preoccupations</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Threat of prison</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Loss of child</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4.27: Participants who identified their relationship breakdown as trigger to their attempt

<table>
<thead>
<tr>
<th>Trigger</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>29</td>
<td>32</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>No relationship breakdown</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Not in relationship</td>
<td>39</td>
<td>43</td>
</tr>
</tbody>
</table>

As shown in table 4.25, more than 80% of the people in this sample identified a social stressor just prior to their attempt. The vast majority of the participants had more than one stressor in their lives prior to the attempt. The main ones were associated with interpersonal problems including relationship difficulties (43%), family problems (32%), and difficulties with children (19%). Housing, legal and financial issues were also identified as being a significant social stressor (see table 4.26 for detail). Relationship breakdown emerged as one of the main stressors. As was described earlier in table 4.3, 25% of the total sample (more than half of those who had relationship difficulties) had left the relationship at the time of their attempt. Table 4.27 shows that around three quarters of those who were experiencing relationship difficulties (32% of total sample) described the relationship breakdown as the actual trigger for the attempt.
Behavioural background

Tables 4.28 to 4.31 present the participants' self reports of general functioning and behavioural backgrounds. Table 4.28 presents participants' reported level of functioning throughout life. Table 4.29 displays the presence of violent behaviour broken down by gender. Table 4.30 reports on problems with anger and gambling while table 4.31 describes the presence of a criminal history.

Table 4.28: Participants’ reported level of functioning throughout life

<table>
<thead>
<tr>
<th>Functioning</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good functioning</td>
<td>50</td>
<td>56</td>
</tr>
<tr>
<td>Chaotic lifestyle</td>
<td>40</td>
<td>44</td>
</tr>
<tr>
<td>Longstanding feelings of disconnectedness</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Drop in functioning</td>
<td>26</td>
<td>29</td>
</tr>
</tbody>
</table>

Table 4.29: Participants who described their behaviour as violent, by gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Violent behaviour</th>
<th>No violent behaviour</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>23 (62%)</td>
<td>14 (38%)</td>
<td>37 (100%)</td>
</tr>
<tr>
<td>Female</td>
<td>13 (25%)</td>
<td>40 (75%)</td>
<td>53 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>36 (40%)</td>
<td>54 (60%)</td>
<td>90 (100%)</td>
</tr>
</tbody>
</table>

Fisher's exact ≤.0001, df=1

Table 4.30: Participants who reported having problems with anger and gambling

<table>
<thead>
<tr>
<th>Problem</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with anger</td>
<td>41</td>
<td>46</td>
</tr>
<tr>
<td>Problems with gambling</td>
<td>27</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 4.31: Participants who reported to have criminal history

<table>
<thead>
<tr>
<th>Criminal History</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal history</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>No criminal history</td>
<td>68</td>
<td>76</td>
</tr>
</tbody>
</table>

As is shown in tables 4.28 to 4.31, marked differences have emerged in the general functioning of this sample. Forty four percent of this sample described their lives as chaotic and around half (56%) described their functioning as good throughout their lives. Around one third (29%) stated that they had experienced a marked drop in their
functioning in the weeks leading up to the attempt (see table 4.28). Twenty four percent reported that, even though they did not lead chaotic lives, they experienced continual feelings of disconnectedness from the world. In addition 40% described themselves as having problems with violent behaviour and 45% identified anger as a problem in their lives (see tables 4.29 and 4.30). As shown in table 4.29 males were more likely than females to describe their behaviour as violent. Sixty two percent of the males versus 24% of the females described their behaviour as violent. This was a statistically significant association ($p \leq .001$, df=1). One quarter (24%) of this sample reported having a criminal history (see table 4.31).

**Family characteristics**

Tables 4.32 to 4.36 describe the family background and adverse childhood experiences such as childhood abuse of participants in this study.

**Childhood experiences**

Table 4.32: Proportion of participants who described their childhoods as chaotic

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaotic family background</td>
<td>35</td>
<td>39</td>
</tr>
<tr>
<td>Family background not chaotic</td>
<td>42</td>
<td>47</td>
</tr>
<tr>
<td>Unknown$^{15}$</td>
<td>13</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 4.33: Proportion of participants who reported a history of abuse/trauma$^{16}$

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of abuse</td>
<td>41</td>
<td>46</td>
</tr>
<tr>
<td>No history of abuse</td>
<td>31</td>
<td>34</td>
</tr>
<tr>
<td>Unknown</td>
<td>18</td>
<td>20</td>
</tr>
</tbody>
</table>

$^{15}$ As described in the Chapter 3, due to the difficult nature of the interviews and the interruptions by the medical team/patients wanting to leave it was not always possible to enquire about the participants’ childhood experiences.

$^{16}$ Childhood and adult – not including emotionally distant parents
As table 4.32 showed, a little less than half (39%) of this sample described their childhoods as being chaotic. Table 4.34 reported that 47% described a history of abuse throughout their lives and 41% reported a history of childhood abuse. In addition to the report of childhood abuse, it is of note that half of this sample (52%) described their parents as being emotionally distant (see table 4.36 for detail).

17 Not including emotionally distant parents
18 Does not add up to 100% as some reported both kinds of abuse.
Family history of mental illness
Tables 4.37 and 4.48 report on participants’ family history of mental illness.

Table 4.37: Participants with a family history of mental illness

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family history</td>
<td>50</td>
<td>56</td>
</tr>
<tr>
<td>No family history</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Unknown</td>
<td>13</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 4.49: Participants with a family history of mental illness, by type of mental illness

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug and alcohol</td>
<td>40</td>
<td>44</td>
</tr>
<tr>
<td>Depression</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Psychotic illness</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>No family history</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Unknown</td>
<td>13</td>
<td>14</td>
</tr>
</tbody>
</table>

Tables 4.37 and 4.38 show that more than half (55%) of the people in this sample have a family history of mental illness, and this is mainly a history of drug and alcohol abuse (44%).

Chronic and acute

Different sample characteristics have been described in this study. These characteristics concern: demographic characteristics, events and circumstances of the attempt, patterns of previous attempts, psychiatric diagnoses, presence of different social stressors, behavioural characteristics and family background and childhood characteristics of the participants.

Of particular interest is the distinction between those who described their functioning up until the attempt as good (56%) and those who described difficulties functioning (including chaotic lifestyle and/or continual feelings of disconnectedness) (44%) and those who described a marked drop in their functioning (29%) (table 4.28). It appears that for some people the issues faced at the time of the deliberate self harm attempt had been present over a long period of time whereas for others these issues had only been present for a relatively short period of time.

---

19 Including drug and/or alcohol abuse.
20 Percentages do not add up to a 100% because more than one mental illness type is possible.
In order to explore this further the sample was divided into two groups: chronic and acute. For the acute group the problems identified were described as having been present for a relatively short period of time, and the participants described a marked drop in their functioning and the problems identified were described as associated with a particular event or situation (such as an illness or a loss). For this group a pivotal event was identified as causing a marked decline in their functioning. In contrast the problems identified for the chronic group were described as having been present throughout most of their lives, often described as starting during childhood.

A particularly difficult group to classify in this manner were those who were experiencing a psychiatric illness such as major depression and schizophrenia. The symptoms of these illnesses could be present for long periods of time; however the people in this group reported good functioning prior to the onset of the psychiatric illness. The illness could be defined as a pivotal event which caused the decline in their functioning and therefore for the purposes of this analysis this group were classified as acute. This classification is consistent with the differentiation between Axis 1 and Axis 2 diagnosis in the DSM IV-TR (American Psychiatric Association, 2000).21

**Division between acute and chronic**

Table 4.39 reports on the proportion of participants who described their problems as acute and those who described them as chronic.

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>33</td>
<td>37</td>
</tr>
<tr>
<td>Chronic</td>
<td>57</td>
<td>63</td>
</tr>
</tbody>
</table>

Thirty seven percent of this group stated that their problems had only been present for a relatively short period of time, whereas 63% stated that their problems had been chronic. The risk factors from the dimensions of family characteristics, environmental factors and mental health problems were cross-tabulated with these two groups.

The following section will report on the risk factors as they cluster in these two groups.

---

21 The characteristics of this group will be described separately in Chapter 6.
**Childhood experiences**

Tables 4.40 to 4.41 report on the childhood characteristics of the two groups (acute and chronic). Table 4.40 reports the proportion of participants who described their childhoods as chaotic, table 4.41 reports those who described a history of childhood abuse, and tables 4.42 and 4.44 report the family psychiatric history and the type of diagnosis. The numbers in these tables only report on proportions calculated on known cases.

**Table 4.40: Distribution chaotic family background according to acute and chronic group**

<table>
<thead>
<tr>
<th></th>
<th>Chaotic family background</th>
<th>No chaotic family background</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute</strong></td>
<td>4 (17%)</td>
<td>20 (83%)</td>
<td>24 (100%)</td>
</tr>
<tr>
<td><strong>Chronic</strong></td>
<td>32 (63%)</td>
<td>19 (37%)</td>
<td>51 (100%)</td>
</tr>
</tbody>
</table>

Fishers exact $p \leq .0001$, $df=1$

**Table 4.41: Distribution of history of childhood abuse according to acute and chronic group**

<table>
<thead>
<tr>
<th></th>
<th>History of Childhood abuse</th>
<th>No history of childhood abuse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute</strong></td>
<td>4 (17%)</td>
<td>19 (83%)</td>
<td>23 (100%)</td>
</tr>
<tr>
<td><strong>Chronic</strong></td>
<td>33 (66%)</td>
<td>17 (34%)</td>
<td>50 (100%)</td>
</tr>
</tbody>
</table>

Fishers exact $p \leq .0001$, $df=1$

**Table 4.42: Distribution of family psychiatric history according to acute and chronic group**

<table>
<thead>
<tr>
<th></th>
<th>Family psychiatric history</th>
<th>No family psychiatric history</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute</strong></td>
<td>11 (46%)</td>
<td>13 (54%)</td>
<td>24 (100%)</td>
</tr>
<tr>
<td><strong>Chronic</strong></td>
<td>39 (74%)</td>
<td>14 (26%)</td>
<td>53 (100%)</td>
</tr>
</tbody>
</table>

Fisher’s exact $p \leq .01$, $df=1$

$^*$ Calculated on all the known cases
Table 4.43: Distribution of Family history of drug and alcohol according to acute and chronic group

<table>
<thead>
<tr>
<th></th>
<th>Family history of D and/or A</th>
<th>No history of D and/or A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>6 (25%)</td>
<td>18 (75%)</td>
<td>24 (100%)</td>
</tr>
<tr>
<td>Chronic</td>
<td>34 (64%)</td>
<td>19 (36%)</td>
<td>53 (100%)</td>
</tr>
</tbody>
</table>

Fisher’s exact $p \leq .001$, df=1

These tables show that risk factors such as a chaotic family background, family psychiatric background (mainly drug and alcohol abuse) and history of abuse are more likely (not exclusively) to occur within the chronic group. Sixty two percent of those in the chronic group (compared to 17% in the acute group) described their childhoods as chaotic; 66% of those in the chronic group (compared to 17% in the acute) reported a history of childhood abuse and 73% of the chronic group (compared to 46% in the acute) described a parental psychiatric history. This was mainly parental drug and alcohol abuse (64% compared to 25% in the acute group).

General functioning

This section reports on the distribution of participants who described their lifestyle as being chaotic and behavioural aspects such as violent behaviour, difficulties managing anger, gambling and a criminal history, according to chronic and acute groups. Tables 4.44 to 4.48 show the details of these distributions. Again the differences between the two groups were found to be statistically significant with $p$ values ranging between $p \leq .002$ and .0001.

Table 4.44: Distribution of chaotic lifestyle according to acute and chronic group

<table>
<thead>
<tr>
<th></th>
<th>Chaotic lifestyle</th>
<th>No chaotic lifestyle</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>4 (12%)</td>
<td>29 (88%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td>Chronic</td>
<td>36 (63%)</td>
<td>21 (27%)</td>
<td>57 (63%)</td>
</tr>
</tbody>
</table>

Fisher’s exact test $P \leq .0001$, df=1

Table 4.45: Distribution of violent behaviour according to acute and chronic group

<table>
<thead>
<tr>
<th></th>
<th>Violent behaviour</th>
<th>No violent behaviour</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>5 (15%)</td>
<td>28 (85%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td>Chronic</td>
<td>31 (54%)</td>
<td>26 (46%)</td>
<td>57 (100%)</td>
</tr>
</tbody>
</table>

Fisher’s exact test $P \leq .0001$, df=1
Table 4.46: Distribution of difficulties managing anger according to chronic and acute group

<table>
<thead>
<tr>
<th></th>
<th>Difficulties with anger</th>
<th>No difficulties with anger</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute</strong></td>
<td>7 (21%)</td>
<td>26 (79%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td><strong>Chronic</strong></td>
<td>34 (60%)</td>
<td>23 (40%)</td>
<td>57 (100%)</td>
</tr>
</tbody>
</table>

Fisher’s exact test $P \leq .0001$, df=1

Table 4.47: Distribution of gambling according to acute and chronic group

<table>
<thead>
<tr>
<th></th>
<th>Gambling</th>
<th>No gambling</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute</strong></td>
<td>1 (3%)</td>
<td>32 (97%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td><strong>Chronic</strong></td>
<td>26 (46%)</td>
<td>31 (54%)</td>
<td>57 (100%)</td>
</tr>
</tbody>
</table>

Fisher’s exact test $p \leq .0001$, df=1

Table 4.48: Distribution of criminal history according to chronic and acute group

<table>
<thead>
<tr>
<th></th>
<th>Criminal history</th>
<th>No criminal history</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute</strong></td>
<td>2 (6%)</td>
<td>31 (94%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td><strong>Chronic</strong></td>
<td>20 (35%)</td>
<td>37 (65%)</td>
<td>57 (100%)</td>
</tr>
</tbody>
</table>

Fisher’s exact test $p \leq .002$, df=1

People classified in the chronic group appeared to have more apparent risk factors compared to those in the acute group. Sixty three percent of the participants in the chronic group (compared to 21% in the acute) reported difficulties with anger. Forty six percent of the participant in the chronic group (compared to 3% in the acute group) reported having a gambling problem and 35% of the participants in the chronic group (compared to 6% in the acute group) reported a criminal history. The patterns observed all show significant differences between the two groups with $p$ values ranging from $\leq .01$ to $.0001$.

**Mental illness**

The following section will report on the distribution of the Axis 1, Axis 2 diagnoses as well as the presence of drug and/or alcohol abuse. Again the acute and chronic groups were found to be significantly different ($p$ values ranged between .01 and .001) Tables 4.49 to 4.51 report on of these patterns.
Table 4.49: Distribution of Axis 1 diagnosis according to acute and chronic group

<table>
<thead>
<tr>
<th></th>
<th>Axis 1</th>
<th>No Axis 1</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>32 (97%)</td>
<td>1 (3%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td>Chronic</td>
<td>44 (77%)</td>
<td>13 (23%)</td>
<td>57 (100%)</td>
</tr>
</tbody>
</table>

Fisher’s exact test P ≤ .01, df=1

Table 4.50: Distribution of Axis 2 diagnosis according to acute and chronic group

<table>
<thead>
<tr>
<th></th>
<th>Axis 2</th>
<th>No Axis 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>5 (15%)</td>
<td>28 (85%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td>Chronic</td>
<td>36 (63%)</td>
<td>21 (37%)</td>
<td>57 (100%)</td>
</tr>
</tbody>
</table>

Fisher’s exact test P ≤ .0001, df=1

Table 4.51: Distribution of drug and alcohol abuse according to acute and chronic group

<table>
<thead>
<tr>
<th></th>
<th>D and/or A abuse</th>
<th>No D and/or A abuse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>8 (24%)</td>
<td>25 (76%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td>Chronic</td>
<td>40 (70%)</td>
<td>17 (30%)</td>
<td>57 (100%)</td>
</tr>
</tbody>
</table>

Fisher’s exact test P ≤ .0001, df=1

As table 4.49 shows, people in both groups are likely (although not exclusively) to be diagnosed with a mental illness. Ninety seven percent of the people in the acute group (compared to 77% in the chronic group) were diagnosed with an Axis 1 diagnosis. Table 4.50 illustrates that people in the chronic group, in addition to having an Axis I diagnosis, are more likely (and again not exclusively) to be also diagnosed with an Axis 2 diagnosis as well as drug and alcohol abuse. Sixty three percent of the participants that described their issues as chronic (compared to 15% in the acute group) were diagnosed with an Axis 2 diagnosis. A similar trend was observed for drug and/or alcohol abuse where 70% of the chronic group (compared to 24% of the acute group) were diagnosed with drug and/or alcohol abuse (table 4.51).

Conclusion Chronic and Acute

The results of this analysis suggests that participants in the chronic group appear to have more apparent risk factors compared to those in the acute group. Participants in the acute group were more likely (although not exclusively) to have been given an
Axis 1 diagnosis. The characteristics of people who describe their problems as being of an acute nature, are significantly different from those who describe their problems as being longstanding. The participants in the chronic group are more likely (again not exclusively) to report: a chaotic family background, a childhood history of abuse, a family history of drug and alcohol abuse, a chaotic lifestyle, difficulties with violent behaviour, anger, gambling and a criminal history. They are also more likely (although not exclusively) to have an Axis 2 diagnosis and to abuse drugs and/or alcohol.

**Summary sample characteristics**

This chapter provided an overview of the characteristics of this sample. People who presented to the Westmead Emergency Department after a deliberate self harm attempt are more likely to be younger, female, single and/or experiencing a relationship break-down and are less likely to be in the workforce (tables 4.1 to 4.4). The majority of the participants in this sample had harmed themselves by taking an overdose, and methods used by men tended to be more violent. One third of this sample attempted to harm themselves whilst they were under the influence of alcohol, and again the proportion of males who attempted under the influence was greater than those of the females (tables 4.7 to 4.9). Differences were also noted in regards to the time when people experience suicidal thoughts. Around half of this sample (51%) had thought about harming themselves for less than 10 minutes, and for a little less than half (46%) there was a shift in the mindset at the time of the interview. Alcohol appears to be one of the contributing factors in the variation of the time of the suicidal impulse (tables 4.11 to 4.15).

Males and females are both likely to have attempted to harm themselves prior to their index attempt. Seventy percent of this sample had made previous attempts. The majority of these attempts (71% of those who had made previous attempts) were made in the six months prior to the index attempt. There appear to be differences within this sample in the patterns of their previous deliberate self harm attempts. For some the attempt appears to be a one off event, whereas others appear to resort to an attempt as a way of coping. For 97% of this sample an attempt appears to be made when the person is confronted with a similar crisis. Differences were noted in regards to the number of attempts. Thirty four percent of this sample had attempted more than five times prior to their index attempt and 18% had made one attempt. In this sample 97% of the participants who had made repeated deliberate self harm
attempts had done under similar circumstances to their index attempt (tables 4.17 to 4.19).

A large percentage of the participants in this sample were diagnosed with mental illness (84%), personality disorders (45%) and drug and/or alcohol abuse. In addition there is strong co-morbidity between the disorders such as depression and drug and alcohol abuse in this sample. Violent and aggressive behaviour, in particular in males, were also associated with a deliberate self harm attempt (tables 4.20 to 4.24 and tables 4.29 to 4.31).

Social stressors (and in particular a relationship breakdown) were strongly present in this sample of people who had made a deliberate self harm attempt (tables 4.24 to 4.26).

Adverse childhood experiences were also strongly present in this sample. Forty eight percent of the sample described their family of origin as chaotic (48%\(^{22}\)) and 51% described a history of childhood abuse (tables 4.32 to 4.36).

The second part of this chapter reported on the first attempt at regrouping participants according to chronic and acute. The results of this analysis suggests that participants in the chronic group appear to have more apparent risk factors compared to those in the acute group. The characteristics of participants who describe their problems as being of an acute nature, are significantly different from those who describe their problems as being longstanding. Several risk factors have been identified as being associated with the chronic and acute groups. This classification was not without difficulties. For example the participants who were diagnosed with a psychiatric illness were particularly difficult to place within this classification and it is possible that the differentiation between chronic and acute is not fine enough to take into account this group and that they may constitute a third group\(^{23}\).

In addition to these differences with respect to the timing of the actual attempt and the state of mind at the time of the interview, it is possible that additional subgroups might emerge when taking into account the timing of the suicidal thoughts and the circumstances and motive of the attempt. As described in Chapter 3, this analysis was undertaken and the next three chapters will report on the results. The next

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\(^{22}\) Percentage is calculated on known cases.

\(^{23}\) This issue will be discussed further in chapter 8.
chapter reports on a detailed analysis of the motives for the attempt and the identified subgroups. Chapters 6 and 7 will describe these subgroups in detail.
Chapter 5: Stage 3 – motives and events

The previous chapter reported on Stage 2 of the analysis in which the varied characteristics and risk factors associated with deliberate self harming behaviour were described. The sample was also divided into two groups, namely chronic and acute.

This chapter reports on the results of Stage 3 of the analysis. This stage focussed on the qualitative analysis of the motives expressed by each of the participants. In this analysis the different motives described by the participants were developed into categories through an inductive process. The different codes and categories developed were further tested against the data and further refined. The analytical process and methods used for this analysis were reported on in detail in Chapter 3.

The first part of the current chapter reports on the results of phase 1 which focussed on the motives participants gave and the way they verbalised these. As was described in Chapter 3, the expressed motives were then scrutinised and coded for content. At the onset in-vivo coding was used. These codes were then developed into more abstract categories. The second part of this chapter reports on Phase 2 of the analysis. In the previous chapters, differences were noted in regard to events leading up to the attempt, as well as a differentiation between chronic and acute. The analytical process was similar to Phase 1 in that it involved unstructured in-vivo coding. These in-vivo codes were then regrouped and more abstract codes were developed. A detailed description of this analysis was provided in Chapter 3.

Phase 1: A qualitative analysis of the expressed motives

Prior to describing the final categories developed in Phase 1, it is important to re-emphasise that, at this phase of the qualitative analysis, the motives reported by the research participants are analysed without taking into account the influence of any mental illness or drug or alcohol use. These factors were only taken into account when the research participants explicitly mentioned them. In this phase only the expressed motives were taken into account for this analysis. Because participants often described a variety of motives, at times it was difficult to separate out and categorise the motives described into discrete themes. To overcome this problem an analytic process was undertaken whereby the whole data set for each case was used.
to provide the information by which main motive, or the most consistent motive described, was identified. This teasing out of the main motive was partly done throughout the interview with the participants and partly post interview. The interview was scanned for different themes and what participants would most often describe.

Finally the results reported on in the first part of this chapter are based on the descriptions that participants gave of their attempt, around the motives they have gave and the way they verbalised these. At this point, these motives are not placed within the context in which the attempt occurred. The influence these factors had on the attempt were taken into account in Phase 2 of the analysis and will be described in the second part of this chapter.

Below are descriptions of the final categories developed in Phase 1 of the analysis. The categories are presented in decreasing order of frequency. The categories are as follows:

1. A way of coping with situation/social stressors (n=25; 28%);
2. A response to rejection, wanting to communicate feelings (n= 23; 26%);
3. A way of coping with mental pain (n= 22; 24%);
4. Influence of mental illness (n=13; 14%);
5. Under the influence of alcohol/other drugs (n=9; 10%); and
6. Did not want to admit to attempt but agreed to be interviewed (n=1, 1%)\(^\text{24}\).

In the next section each category will be briefly described and a typical comment made by people expressing these intentions.

1: **A way of coping with situation/social stressors(n=25; 28%)**

In this category the main motive for the attempt was described as a way of coping with their problems/social stressors. For most of the people in this category there were also elements of wanting to communicate their distress to others. This group was subdivided into four subcategories: a) to get away; b) death is easier than dealing with the situation; c) a “paper bag that just exploded”; d) wanting to be taken care off.

\(^{24}\) The sixth category was included because one person did not admit to having harmed herself deliberately even though the treating registrar and the researcher both felt that it was a deliberate self harm attempt. She did however agree to be included into the study, even though the study was described to her as a study which wants to understand people who attempted to harm themselves deliberately. For the purposes of this classification she was classified separately.
To get away (n= 5)
For people in this group the actual attempt was a way of escaping their problems. They described difficulties in dealing with their emotions when problems occur. The attempt was a way of getting away from the situation that overwhelmed them. There was an ambiguity in the attempt, in that the respondents stated they wanted to get away from the situation, but often did not think that if they died, they would not be here to actually experience the peace. Death was conceptualised as wanting to get away or to sleep. The intention can be subdivided into those who clearly stated that they just wanted to get away from their problems and those who felt more passive about this and just wanted to go to sleep.

“It was just basically that – everything that had happened over the last couple of years. I didn’t really think about what was going to happen if I died. To just get rid of everything, everyone. I just wish we [talking about herself] could go away. That’s why I did it. Go away. [...] I just want to get away. I just want everything to go.” (RP 79)

“Just the build up [lists the issues] you know the build up and [...] I just wanted to get out of the thoughts for a while.” (RP 24)

To get away from a stressful situation (n=11)
This group conceptualised death as being a solution to their ‘problem’. The attempt was a way of solving their problems and they believed that death was better than having to face the current situation. They were unable to see any other possible solution to their situation. Rather than wanting to get away from their problem they chose death as a solution to their problem.

“[The attempt was] to escape prison; to escape being raped.” (RP 70)

“[...] and I thought ‘why don’t you just finish it, and get on with it?’ [...] I felt like I sort of euphoria, thinking ‘yeah, that is a solution to a problem!’ Because my whole life has been a series of disappointments, heart aches, traumas, my whole life, from nearly the time I was born.” (RP 40)

It just exploded (n= 6)
This group saw the attempt as a way to get away from their feelings. However the attempt was described as an explosion and they felt that it was out of their control. The act of self-harm was less deliberate than for the previous two groups. Each
respondent described their attempt as a way of wanting to be at peace and having time out from stressors.

“It was like a paper bag that just exploded.” (RP 25)

“I honestly don’t believe I wanted to die. Because I didn’t plan to take the pills or anything like that. I just wanted to get away from it, you know? You want to get away from something and you don’t know how to do it […] It’s like a big saucepan of stew going round and round and round, all in one way, and then all of a sudden something just happens and then it goes around in every different way, and you can’t get out of this saucepan of soup. You’re there and all you can see is this hole in the bottom, and that’s where you want to dive to, down there. Yeah, (laughs) that’s the best way I can describe it, anyway!” (RP 73)

**Wanting to be taken care of (n=3)**

In three cases there was clear evidence that the actual attempt was a means to solve a problem. The solution these respondents had found to their problem was to be admitted to hospital. They wanted others to look after them as they felt unable to cope with life. All three people expressed feelings of being lonely, uncared for and unable to care for themselves. In one of the cases the respondent stated that he had taken an overdose of more than 100 tablets but he had no physical symptoms. He was experiencing housing problems at the time and did not have anywhere to go. The other two cases had slight cognitive impairment and both described feelings of being lonely and asked on different occasions throughout the interview when they were allowed to go to Cumberland (a psychiatric facility) because people would take care of them there.

“I really can’t explain it any more than saying I was trying to get accommodation or look for a place to stay out that way. Um, and then it just went from ‘who gives a fuck?’ to ‘I don’t care anymore’ to ‘I just want to kill myself’. […] I don’t know, I was at a loss as to how to go on. It’s like I picked up the ball and I ran with it all the way down to the end field, now all I’ve got to do is work out wherever I was going to make a touchdown, or whether or not I was going to make an impasse – and, like, well, I made a touchdown by going to the hospital, and then they, like, transferred me to Cumberland.” (RP 75)
2: A response to rejection, wanting to communicate feelings of hurt (n=23; 26%)
This group described the attempt as a way of coping with their feelings following a rejection by a significant other. They spoke of feeling that life was worthless without that person and/or that their quality of life was not the same without them. Some reported that they ceased to exist without the presence of the other person. In most of the cases there were elements of the respondent wanting to communicate these feelings to the person that they feel they had lost. The communication was either explicitly described or implicit in their actions where they either attempted in front of the person or rang the person after the attempt to tell them what they had done. The motive for the attempt incorporates a desire to die (as life seemed to be worthless without that person) as well as the desire to make the other understand the hurt they had caused.

“Really it is her life and she can do what she wants, but this is my life and I do what I want. [...] I don’t want it anymore. [...] I know where I stand now. I just wanted to show her how much I loved her [Cries, very long silence in interview].” (RP 43)

“It’s [attempt has] totally to do with my girlfriend. It’s all to do with my girlfriend. [...] It’s her cheating me. I am the one who feels it all and she does not give a fuck. And it hurts me.” (RP 59)

3: A way of coping with mental pain (n= 22; 24%)
The third group described their attempt as a way of coping with their feelings. This group was subdivided into three subgroups: 1) feeling of little value, 2) to stop feeling the way they do, and; 3) wanting the make the mental pain physical.

Feeling of little value (n=12)
This subset described their attempt as a means of coping with the mental pain caused by the feelings of self hatred towards themselves. They felt that their lives were inconsequential. They reported feeling that they took up space that they were not entitled to and that everyone else were able to live their lives but the respondents were unable to do so.

“It does not matter it [life] is inconsequential, in the whole scheme of things, who cares, it is what do they say, a drop in the fucking ocean. It does not matter.” (RP 53)
“And life’s been pretty rotten right from the start. [...] I feel that] the air I breathe, the ground I walk, this bed is all a waste.” (RP 95)

In two cases the main intent described as wanting to punish themselves for having been in some way ‘bad’. They felt guilty about the fact that they had let themselves get into difficult situations. These feelings are part of general feelings of hatred towards themselves.

“I wanted to burn from inside. Harm myself. Punish myself for letting myself get into such a predicament where I hated being overprotective of [partner]. […] I feel I’m not worthy of his love.” (RP 80)

To stop feeling like they do (n=8).
A further subset were attempting to cope with the mental pain were those who described having difficulties in understanding the way they are feelings and generally described feeling overwhelmed. They spoke of a long standing feeling of being disconnected from the world and not understanding why. The confusion around their feelings was also present in their description of the actual attempt, which ranged from an impulsive action to thinking through the details of the event.

“When I take tablets, I think I do, or I take tablets and I get so out of it, so that I do not have to put up with the pain. […] It’s I think, it is something that you want to kill pain. It is like a needle, it is like an injection and people that do want to kill themselves will kill themselves. (RP 32)

“I think the main reason I tried to take my life is because what happened to me [sexual abuse]. Like, I try to get away from it at work, so I think if I take my own life I won’t have to remember any of that and I won’t have to worry about it. […] I was just trying to figure it out myself, you know? What would be the quickest way to knock myself out, you know? And I thought, I don’t want to stab myself or something because, you know, I don’t want blood everywhere and that would look too obvious, I just want something like, to fall asleep, and I thought to myself, if I’m going to die I’m going to die in my sleep. And what’s going to knock me out, make me go to sleep?” (RP 17)

Interviewer: You wanted to get away from your feelings? From yourself a little bit? Is that what it is?
RP: Hmm exactly (RP 49)
Others in this group explicitly stated that they just wanted the mental pain they were experiencing to stop.

“I just wanted the [mental] pain to go away.” (RP 22)
“I just want the [mental] pain to stop.” (RP 87)

**Wanting to make the mental pain physical (n=2)**

A further subgroup of people who sought ways of coping with the mental pain were those who harmed themselves physically in order to make their mental pain physical. When this strategy did not work, the respondents in this subgroup reported taking overdoses to deal with the feelings.

“It [cutting] just distracts you, it really does. It helps a lot in that respect, it is the way it just brings you back to reality. It is just like: I have done this thing that is physical, rather than just something that you can’t put into words in your head.” (RP 10)

**4: Influence of mental illness (n=13; 14%)**

The fourth group described their attempt as a response to their difficulties coping with their mental illness. This group was separated into three subgroups: 1) stop the depression; 2) voices involved and 3) confused/thought disordered.

**Stop the depression (n= 5)**

The people in this group all suffered a major depression (one respondent from an anxiety disorder). All of these people described feelings of hopelessness about their illness and felt that their illness was never going to stop. Those who were diagnosed with depression described their attempt as wanting to stop the depression. The person diagnosed with anxiety disorder wanted to end his fear of a heart attack.

“Well, the only time I’ve ever self-harmed, including this time, has been during a depressive episode of my illness, like, bipolar disorder. And I’ve been depressed, I guess, [for 4 months] […] I don’t want to die. Just want to stop the depression.” (RP 77)

“Life was so good without the depression.” (RP 29)
Voices involved (n= 3)
The people in this group were diagnosed as suffering from schizophrenia and reported hearing voices. They spoke of the voices suddenly attacking them and the only way to escape them was, for example, by taking an overdose. All of the people in this group felt they had little control in this state of mind. The attempt is a way of dealing with the distress they experienced as a result of the voices. When they were in this state of mind they did not reason that they would not be here if they had died.

“They (the voices) just attack me.” (RP 39)

“To stop the voices. Heard enough of the voices. I wanted to die, I’ve had enough of them. It’s what happens all the time, it starts off with trying to get rid of them. Then it’s like I don’t want to put up with this anymore and then it is like self-harm and then I start thinking of ways to die. It’s just like a car, really. When it gets started you’ve got to actually drive it. It’s just the same thing. Find the steps I’ve got to take. And first it’s like, oh, I really want to get rid of them and that’s the thing I’m doing, but I take all the pills and then I won’t listen to them, and then I wake up here. So I’m slowly trying to get rid of them, but they obviously overpower me.” (RP 91)

Confused/thought disordered (n= 5)
The people in this group were unclear about what was happening to them. All of the people in this group described the mindset they were in at the time of their attempt as different from their normal state and had difficulties recognising themselves. It was as if they were working with a different internal logic, which limited the way they were able to solve problems. The attempt was described as being part of this logic. The mindset they described coloured their thinking.

One person in this group had difficulties processing information and was very concrete in her answers. She described feelings of being hurt by other people’s behaviour but had difficulties processing her feelings because of her cognitive abilities.

During the psychiatric assessment one young man stated that before he started to feel confused he was able to relate to people, but that now he was staying at home all the time and he is unable to communicate with others. He attempted because of his confusion. (RP 19)

He was not thinking clearly, he thought that people were following him and were going to kill him. He thought that if he had to die, he was not going to give them the satisfaction of killing him. (RP 52)
5: Under the influence of alcohol/other drugs (n= 9; 10%)  
The people in this group were less clear about the actual intention of the attempt. There was clear evidence that the actual attempt was made deliberately and the participants were clear that it was a deliberate self harm attempt, however the exact thought process behind remained uncertain. The people in this group stated that they started using the drug and/or alcohol as a way of coping with their feelings and made the attempt while they were under the influence of these drugs. All the people in this group described feelings of depression and wanting to die; however the exact reasoning and thought processes they went through at the time were unclear to them. They had all consumed large amounts of alcohol or drugs prior to the attempt. The people in this group described the process of their attempt as feeling depressed and drinking alcohol to deal with their depression.

“I am not sure what happened last night [as I was drunk] I only remember that I took tablets … and that I wanted to die.” (RP 7)

“To tell you the truth I got no knowledge. I do got knowledge of taking the medication [to die], but I don’t have knowledge on what made me do that. I do not know, and it has happened a couple of times. And I just try to find the right answer to ‘why?’” (RP 8)

6: Did not want to admit to attempt but agreed to be interviewed (n=1; 1%)  
In one case the actual intent was most unclear. The respondent stated that she did not know why she had shot herself and presented her issues in terms of physical discomfort. However when she was interviewed two days later by the treating psychiatrist she stated that at the time she wanted to die because she felt that she was unable to cope with the issues that were going on for her and that she had been feeling depressed for quite some time. The researcher was not present at this second interview and therefore unable to comment on the nuances of this attempt.

Summary  
From this analysis it was apparent that people who attempt to harm themselves do so when they are experiencing a great amount of pain and the deliberate self harm attempt is made as a response to this pain. Participants described this pain in different ways, including wanting to escape situation/social stressors, mental pain,
confusion or a mental illness and for half the attempt appeared to be made to ‘solve their problem’. Shneidman (1993) has also described this mental state. He described the suicidal act as a response to an unbearable Psychache. The term Psychache referred to feelings of hurt, anguish, soreness, aching, psychological pain in the psyche, the mind (Shneidman, 1993). The motives described above are consistent with those described by Shneidman.

**Theoretical difficulties with classification**

Although the categories described above highlight different aspects of the state of mind people are in at the time of an attempt, this classification is not without difficulties. These are mainly relating to finding discrete and fixed groups within the sample. Even though all efforts were made to ensure that the main motive described reflected the participants’ state of mind at the time of the event, a degree of interpretation on behalf of the author was involved in the analysis to identify a dominant motive for the event. Participants often expressed a mixture of motives and it is possible that if they were to classify themselves they may not always be able to identify the dominant motive for their attempt or would nominate a different motive to the one identified by the author. This has also been highlighted within the literature where people often endorse a mixture of motives behind their attempt (Bancroft et al, 1976; Williams, 1986; Williams, 1997). In addition, as discussed in Chapter 3, motives appear to change over time and it is possible that if participants were asked in a few months about the motive for their attempt, they may give a different answers. Similarly, as discussed in Chapter 4, a deliberate self harm attempt can have a cathartic effect on the mental state of people who attempt to harm themselves and their recall of the motive of the attempt may be tainted by their mental state at the time of the interview.

At times even when the expressed motives appear similar, the circumstances and events leading up to the deliberate self harm attempt were vastly different. For example RP 89 and RP 92 both described their intentions as wanting to go to sleep and/or to have time out from their problems. However the problems described were different. RP 89 was facing numerous social stressors at the time of the attempt and she wanted to have some “time out” from these. For RP 89 the problems had only started three weeks prior to his attempt and she was tired of having to deal with them and felt that death was an easy way out. In contrast, RP 92 was facing relationship problems but she had been felt like killing herself prior to that. The relationship breakdown activated the underlying feelings of disconnectedness with the world and
she described the actual stressors as awakening longstanding underlying feelings of disconnectedness. Both expressed their attempt as wanting to sleep, however the process underlying in both attempts appeared to be different.

These issues suggest that motives alone, are not sufficient to regroup participants and additional dimensions need to be taken into account when attempting to categorise people who have made a deliberate self harm attempt. A second level of analysis was undertaken and a new a coding framework was developed. This coding framework contained the following dimensions:

- Whether the problems the respondent described were chronic (longstanding) or acute (pivotal), as was analysed in Stage 2;
- The persistence of thoughts of self-harm (impulsive or nonimpulsive/deliberate) and the presence or absence of these feelings at the time of the interview (the resolution of the attempt); and
- The types of problems/situations and triggering events the person described as wanting to escape (generally referred to as motive).

The next section presents the results of this analysis. The categories developed are briefly presented in this chapter. The characteristics of these groups (Stage 4 of the analysis) will be described in more detail in Chapters 6 and 7.

**Final categories - Phase 2**

The final coding categories were as following:

**Acute group**
1. Psychiatric condition
   a. Depression
   b. Schizophrenia
2. Social stress
   a. Impulsive
      i. Overwhelmed
      ii. Gain control
   b. Non impulsive (loss of self)

**Chronic group**

3. Longstanding drug and Alcohol issues
   a. Impulsive: Under influence
      i. Alcohol
      ii. Drug induced psychosis
b. Non impulsive: Withdrawal

4. Social stress
   a. Impulsive
      i. low self worth
      ii. Self hatred
   b. Non impulsive (disconnection)

Below are detailed descriptions of the different groups that were identified.

**Acute subgroups**

Acute group: Participants described their problems as having been present for only a short period of time. The problems identified were:

**Group 1: Acute - psychiatric condition**
The main problem described by this group was their psychiatric illness. The participants in this group described their functioning as good prior to the onset of their illness. They attempted in this state of mind and reported they were attempting to escape the pain of their illness. This group is divided into two subgroups:

*Non impulsive -depression*
Participants in this group described their attempt as being deliberate and was characterised by intense feelings of depression associated with a diagnosis of major depression/bi-polar disorder. The feelings of self harm were still present at the time of the interview.

*Impulsive - schizophrenia*
The attempt in this group was characterised by short lived feelings of confusion associated with a diagnosis of schizophrenia or mania. At the time of the interview, participants still described feelings of confusion, but the pressing thoughts they described at the time of the attempt had disappeared.

**Group 2: Acute- social stress**
People in this group described their functioning as good, prior to different social stressors. The attempt was described as a reaction to social stressor(s). This group was subdivided into those who had made the attempt on impulse and those who did not.

*Impulsive*
Participants in this group described their attempt as an impulsive reaction to social stressor(s). At the time of the interview, the impulse to harm themselves had
disappeared and they described feeling their “normal” selves again. Originally participants in these two groups were placed as one group as the participants in both groups did described short lived feelings of depression around social stressors. However it became apparent that two groups were required when the actual motives described at the time of the attempt were found to be different.

**Impulsive (overwhelmed)**
The attempt was characterised by short lived feelings of depression, in response to a large number of stressors. They experienced high stress levels and were unable to cope. Participants in this group attempted to harm themselves because they felt overwhelmed by the stressors they had been experiencing and their attempt was an escape from these.

**Impulsive (gain control)**
Participants in this group experienced relationship difficulties with a significant other and the attempt was prompted by an argument with their significant other and they described their attempt as being directed towards that person as an attempt to communicate their feelings and/or to gain control over the situation. The attempt appeared to be linked to a situation in which they lost control (mainly a relationship breakdown). The attempt was described as being unable to deal with feelings of loss of control. Participants described short lived feelings of depression when dealing with feelings of being out of control about the loss of relationship. They describe the action as an attempt to show the other person how serious they were about them and of their feelings.

**Non impulsive**
Participants in this group described their functioning as good prior to the onset of the social stressor(s). They described an inability to cope with the social stressor(s) and described a gradual decline in their functioning and the development of depressed feelings over a period of one to four weeks. The attempt was characterised by intense feelings of depression, present over several weeks, after a significant loss (relationship or employment). The participants in this group stated that their life was hopeless and pointless without the person (or employment) they were losing. They experienced similar feelings at the time of the interview.

**Chronic subgroups**
The participants in the chronic group described their problems as being present for most of their lives. People in this group described longstanding difficulties in coping
and the attempt sat alongside many dysfunctional behaviours. Two subgroups were identified.

**Group 3: Chronic - Longstanding drug and alcohol issues**
Participants in this group described long term problems with drug and/or alcohol. They described starting to drink and/or taking drugs in response to feeling depressed and/or having to deal with minor social stressors. The actual attempt was described as stemming from these underlying feelings of depression which were accentuated by the influence of drugs and/or alcohol.

*Impulsive - Under influence of alcohol*
Participants in this group described having difficulties dealing with minor social stressors or were feeling depressed. They started drinking as a mechanism to cope with these feelings, and as a means of not having to think about their problems. They attempted to self harm on impulse, while under the influence of alcohol, and often could not remember what they were thinking at the time of the attempt. The participants in this group had a marked shift in their mindset at the time of the interview.

*Impulsive - Drug induced psychosis*
Participants in this group attempted to harm themselves whilst they were experiencing a drug-induced psychosis. The attempt was made on impulse. The psychosis and feelings of self harm had lifted once the drugs had disappeared from their system. They described a marked shift in their mental state at the time of the interview.

*Non impulsive (drug withdrawal)*
Participants in this group described a binge on speed/heroin binge. They had stopped using drugs in the weeks leading up to the attempt and started to experience feelings of depression. Participants in this group had thought about harming themselves for a long time. They were experiencing similar feelings at the time of the interview.

**Group 4: Chronic – Social Stressors**
Participant in this group described longstanding difficulties functioning. The attempt was made as a reaction to social stressors; However, the social stressors were described as activating underlying feelings of depression and/or disconnectedness.

This group is also subdivided into those who had made an attempt on impulsive and those for whom the attempt was non-impulsive. Prior to describing the groups it is
important to note that originally the two subgroups non impulsive (disconnection) and impulsive (self hatred) were originally conceptualised as similar, because of the way the participants who were classified within these two groups reacted to social stressors. The participants in both groups attributed their attempt to underlying feelings of disconnectedness or self hatred. These feelings were described as having been present during most of their lives. The stressors were described as triggering events for these feelings to surface, and the deliberate self harm attempt was made to alleviate and/or escape these feelings. At the time of the interview the impulse to harm themselves has disappeared for most of the participants in these two groups; however the underlying feelings were still there. Both groups were likely to have made multiple attempts to harm themselves. They were separated based on the impulsiveness of the attempt. However it is possible that the group self hatred is a more severe form of the group disconnection.

**Social stressors –impulsive**
This group was subdivided into two groups namely disconnection and self hatred.

**Impulsive - Low self worth**
Participants in this group identified the loss of a relationship as a triggering event. The attempt was described as short lived feelings of depression with feelings of disconnection described as being present throughout most of their lives. The attempt was described as a means to make others understand how they felt. The participants in this group described a marked shift in their mindset at the time of the interview.

**Impulsive - Self-hatred**
This group described underlying feelings of self hatred. The attempt is made as a way of escaping these feelings. The attempt was made as a reaction to a single stressor. They reported wanting to have time out from the way they had been feeling. They reported similar feelings at the time of the interview.

**Non impulsive – disconnection.**
Participants in this group described ongoing feelings of wanting to harm themselves. Even if the attempt was described as impulsive the thoughts of self harm were described as omnipresent. This group described underlying feelings of disconnectedness with the world. The attempt was described as a way of escaping these feelings. They described ongoing low levels of depression and reported a single stressor which appeared to ignite the underlying feelings of disconnectedness. Participants in this group described ongoing feelings of wanting to harm themselves. This group reported experiencing similar feelings at the time of the interview.
Conclusions

This classification of groups took into account life experiences (in particular to whether or not the problems described were acute or chronic) of people who attempt to harm themselves and the circumstances preceding and surrounding an attempt (in particular triggering events, time of suicidal feelings, motives described and resolution of the attempt). The categories developed have been able to account for 96% of the sample which suggests a refinement of our understanding of deliberate self harm\textsuperscript{25}. The following two chapters will report on the characteristics of the acute and chronic.

\textsuperscript{25} Four cases were not classified and will be described in more detail in Chapter 7.
Chapter 6: Stage 4 - Acute Group

The previous two chapters reported on the findings of Stages 2 and 3 of the research. They described the characteristics of the sample and the motives that were associated with a deliberate self harm attempt. Chapters 6 and 7 will report on Stage 4 of the analysis where the quantitative data from Stage 2 (presence or absence on known risk factors) and the narrative summaries of the motives were linked to the groups identified in Phase 2. This chapter will describe the demographics, risk factors, mental illness, childhood experiences, general functioning, previous attempts, circumstances of the attempt, Psychache described and the impact of the attempt associated with the acute groups. Participants in this category described their problems as having been present for only a short period of time. Three acute groups will be examined in this chapter. These groups include those with a psychiatric condition, those who made an impulsive attempt motivated by social stressors and finally those that made a non impulsive attempt motivated by social stressors.

Acute: Psychiatric condition (n=12)

There were 12 participants in this group. Each participant had a psychiatric condition (major depression, anxiety disorder or schizophrenia). However, because of the differences within the aetiology of the mental illnesses, this group was separated into two subgroups. First were those with a main diagnosis of depression or anxiety disorder, and secondly those for whom the main diagnosis was schizophrenia, drug induced psychosis or manic phase of bi-polar disorder (American Psychiatric Association, 2000).

Acute: Psychiatric condition - depression (n=5)

Demographics
This subgroup relates to those diagnosed with depression and is comprised of one male and four females mostly aged between 35 and 54.

Risk factors
Mental illness
All the participants in this group were given a psychiatric diagnosis. These included: major depression (n=3) bi-polar depressed state (n=1) and anxiety disorder (n=1). Four out of the five did not have an associated Axis 2 diagnosis.
**Childhood experiences**

None of the participants in this group reported a history of childhood abuse or described their childhoods as chaotic. Two participants had described their parents as being emotionally distant, and these parents had a diagnosis of depression.

**General functioning**

All the participants in this group reported good functioning prior to their mental illness. Only one person described experiencing feelings of anger and violent outbursts at the time of his or her attempt. These feelings had started around the same time as the symptoms of their anxiety disorder.

**Previous attempts**

Three out of the five respondents had made previous deliberate self-harm attempts in the past. All described their previous attempts as occurring during an episode of mental illness. One respondent described it as follows:

“...The only time I’ve ever self-harmed, including this time, has been during a depressive episode of my illness, like, bipolar disorder. [...] I have never thought about it when I wasn’t depressed. Never, ever. Never.” (RP 77)

**Circumstances of the attempt**

All five participants attempted whilst they were experiencing an episode of depression/anxiety. All had been experiencing these feelings for a long time and felt that the depression/anxiety was never going to end. The actual attempt was described as being quite deliberate. Three out of the five had thought about harming themselves for over six hours. The other two stated that they had made their attempt on an impulse five to 10 minutes and 30 to 60 minutes respectively, but both stated that they had been thinking about harming themselves within the week leading up to the attempt. There was no reported trigger prior to the event, and even when a social stressor was reported this was not considered to be a trigger factor for the attempt.

For example

RP 88 stated he had been fearful of a heart attack for 3 months prior to his attempt and had been thinking about pre-empting this on different occasions. The afternoon of the attempt he had a small argument with his wife after which he started drinking. He made the decision to die on an impulse that afternoon; however the thought had been there for quite some time. (RP 88)
All of the participants in this group reported a sense of relief when they had made up their minds about harming themselves. For example RP 48 described the sequence of events as follows:

“I had made up my mind [on the Friday], but I’d agreed to do some things with some friends on the weekend so I kept those commitments on the Saturday. I did actually feel a bit better after I had made up my mind […] that Sunday night, went to bed, got up the next morning, rang work, made some excuse as to why I couldn’t come in […] I got up and went to the pharmacy, you know, doing my best not to look anything other than completely normal so that they wouldn’t suspect anything […] then I went back to the pharmacy again, got the medication and came home, and just, um, swallowed everything that I had and went to bed.”
(RP 48)

Only two of the participants described social stressors leading up to the attempt; however both stated that they had difficulties coping with these stressors because of their illness. Both stated that the stressors were not the actual cause of their attempt.

For example RP 77 described the events leading up to her attempt as follows:

“And I had all the same symptoms that I had before, the depression, you know, waking early in the morning, finding it very difficult to cope with the smallest things when normally I feel that I cope very well. I’ve got two small children and I’m a single parent and when I’m well I was studying at uni, I had a full time job, when I’m sick I can’t do anything. […] The children went to school and I decided that I’d put an end to this depression because I couldn’t cope with it.” (RP 77)

Psychache
All of the participants in this group described their intent as a way of dealing with the emotions surrounding their illness. For all five the pain of their mental illness had become overpowering and their attempt was made in order to stop the depression/anxiety they had been experiencing.

“There was just this huge level of exhaustion and despair and hopelessness – um, so I had been, I sort of felt as though I’d kind of, I’d come to the end of what I could do […] I had made myself very calm as a prelude to this,
because I thought, ‘I don’t want to die in the grip of fear, I just feel that I don’t want to continue to live any longer, you know, but I don’t actually want to create a great song and dance around it.’” (RP 48)

“I don’t want to die. Just want to stop the depression.” (RP 77)

**Impact of the attempt**

All five still felt the same at the time of the interview as they had at the time of the attempt. Four participants were still feeling suicidal and were unable to guarantee their safety if they were released. Although they felt safe in the hospital, the difficulties they experienced in dealing with their illness had not disappeared and they were each admitted as an inpatient to the psychiatric ward.

_Interviewer: Do you still feel the same as before overdose? Do you still feel the same now?_

_RP: I think so. I mean, I guess I’m - I don’t know what would happen if, you know, I were discharged now, um, but I think it’s quite likely that I would, you know, think of another way of killing myself at the moment. Because nothing’s changed, nothing’s been resolved yet.” (RP 48)_

**In summary** the participants in this group are in middle adulthood. All had an Axis 1 diagnosis, which had impaired their functioning in the weeks leading up to their attempt. Only one person in this group also had an Axis 2 diagnosis. None of the participants in this group reported a history of abuse, a forensic history or violent behaviour. Only one person had an additional diagnosis of drug and alcohol abuse and this had only started at the onset of their psychiatric illness. For those who had made previous attempts, these only occurred during an episode of mental illness. For all of the participants in this group the actual attempt had been quite deliberate. The self harm attempt could be understood in terms of a response to the pain of the mental illness, and stemming from the feelings of depression (or anxiety) and their difficulties in coping with their mental illness. All of the participants in this group were still feeling the same the same the next morning and most participants were admitted to the psychiatric ward. The following case vignette further illustrates this subgroup.26

_Paula:_

26 The case vignettes in this thesis are composite cases of participants. Pseudonyms are used.
Paula is a 37 year old female who had been diagnosed with depression since the age of 18. She had been experiencing bouts of depression on and off throughout her life. Recently the depression had been really severe and she had not been responding well to her medication. In the weeks leading up to her suicide attempt she had found it more and more difficult to get out of bed and had been isolating herself from her friends. She felt that she had become the depression, and decided that she did not want to continue living like this. She felt surprisingly calm after she had made the decision and started to make arrangements for her death. She did not talk to anybody about her decision to end her life; however she started to give away some of her belongings and she wrote a Will. She then took a large overdose and was waiting for her death to come. After about 1 hour she started to vomit and experienced pain. She then rang the hospital as she did not want to die in pain. The next morning she was still feeling the same sense of hopelessness about her depression: “I don’t want to die, I just want to stop the depression.”

**Acute: psychiatric condition – schizophrenia (n=7)**

**Demographics**
The second subgroup within psychiatric condition relates to those diagnosed with schizophrenia and bi polar disorder (manic phase). Participants in this group were all under the age of 34. There are three men and four women in this group.

**Risk factors**

**Mental illness**
Six of the seven participants in this group had a diagnosis of schizophrenia and the other one was experiencing a manic episode. None of the participants in this group were given an Axis 2 diagnosis.

**Childhood experiences**
Only one person in this group reported their childhood as being chaotic; however because of their confused mental state at the time of the interview, the data collection of childhood experiences was difficult. Of note is that five out of this group reported a parental history of mental illness and these included more chronic mental illnesses such as psychotic disorders and major depression. Three members also stated that one of their parents abused alcohol.

**General functioning**
All of the participants in this group had difficulties functioning at the time of their attempt, but reported that they had been able to work prior to the onset of their
illness. Because of the symptoms of their illness the participants in this group experienced problems with housing and work. None of the participants in this group were able to work or live by themselves and three were homeless at the time of their attempt. Other social stressors mentioned by this group were problems relating to their family and friends because of their illness. All reported a major drop in their general functioning because of their illness. Four participants also described their behaviour as violent and all four had started to become violent at the time of their illness. The four described their anger/violent behaviour as the result of feeling frustrated with their illness. They exhibited this behaviour when they were in crisis and associated their violent behaviour with their illness.

Drug and alcohol abuse

Five of the seven in this group abused drugs and/or alcohol, mainly a combination of drugs. All five described their drug use as a way of controlling their symptoms. In all five cases they described a constant interaction between the actual drug use, their illness and their desire to control their symptoms. Three participants described the drug use as initially a way to help them feel more relaxed. However, they each went on to say, however, that over time their drug use intervened with their mental illness, and made them feel worse. They continued to utilise the drugs to try to control their symptoms, which further exacerbated their illness. The case presented below clearly shows the constant interaction between the drugs and the illness. RP 91 had been taking a lot of drugs over a period of five months and started to subsequently hear voices. His functioning declined quite severely over this period. He then started to take drugs to control the voices, which in turn aggravated his illness. It was unclear if the psychotic phenomenon was primary or secondary to his drug use. At the time of his deliberate self harm attempt he was given a diagnosis of schizophrenia. The following is an abstract from the interview where he describes the interaction between the drug use and the illness.

“Yeah. [I have been hearing voices for] about a year. A bit longer than that, but I worked out that that was the drugs doing that, voices from other participants. About a year all up, yeah, and really getting heavy at the start of the year, this year and stuff, and then it started getting bad in the last couple of months to couple of weeks. […] [The drugs] get rid of them, yeah. It gets rid of them easily. Not all the time, sometimes I’ve got to take more and more.” (RP 91)
Previous attempts
Six of the seven in this group had previously attempted to harm themselves in the past. In all cases these attempts occurred when they were experiencing an episode of their illness. RP 91 described his previous experiences as follows:

“I never do [remember what happened]. I just remember bits before it and then voices and I know, I wake up feeling it’s got something to do with them straight away.” (RP 91)

Circumstances of the attempt
The overarching theme of the interviews was the confusion about their feelings or the overpowering nature of the voices. For all five the Psychache was associated with their mental illness.

Psychache
It appears that the actual attempt for the participants in this group was quite impulsive. The mental state they were in at the time of the attempt had been present for quite some time. The actual suicide attempt was described as an overwhelming reaction to when they felt overpowered by the voices. The transcripts below illustrate this concept.

“I’m slowly trying to get rid of them [voices] but they obviously overpower me.” (RP 91)

“They [the voices] just attack me.” (RP 39)

He could not remember what happened and stated: “I just wanted to calm down.” (RP 19)

All the participants in this group described their attempt in very similar terms. Four participants described a general confusion about their lives at this time. For example:

RP 19 was very confused about what was happening to him and he was unable to answer any questions about his feelings. He was not sure about what had happened. He said that it was to calm him down, but at the same time he thought that he probably intended to die. (RP 19)

One person who described a general confusion also expressed feelings of depression about his situation. During the interview his thoughts were still slightly disordered. The interview had to be stopped when he started talking about faeces. In this case it was unclear how much of the attempt was influenced by the actual thought disorder or by the feelings of depression about his situation. It might well be
that there is a sub-cluster of participants who have been diagnosed with schizophrenia, and felt depressed about their illness. Below is the abstract from the interview where he talked about his situation. Off tape he talked about how he felt that his life had been difficult ever since he had been diagnosed with schizophrenia 10 years prior to his attempt. He did not want to live the way he was anymore. He stated:

“I just wanted to get really out of it. [...] Because everything’s so fucked [...] for ten years I’ve been living off the street. Ten fucking years. Ten years of fucking hell.” (RP 85)

The three remaining participants in this group expressed clearly that they felt overpowered by the voices in their head and did not know any other way of stopping them. For example:

RP 34 wanted to get away from the voices. She did not realise that the tablets she took could kill her. (RP 34)

“Stop the voices. Heard enough of the voices. I wanted to die, I’ve had enough of them.” (RP 91)

Although the intents were different, what they had in common was that for all the participants the actual attempt was a response to the overpowering nature of their illness.

**Impact of the attempt**

All seven in this group reported hearing voices at the time of the attempt. Their mental state at the time of the interview had changed as they were able to rationalise from the previous night. Their suicidal feelings had subsided because the participants reported that the overdose had calmed the voices and/or the confusion. They were feeling safe in the hospital. The imperative nature of the voices appeared to have lifted for the time being. However although they appeared to understand the mechanisms of their attempt, they each still felt that they would be unable to stop the voices and the attempt from happening in the future. For example, RP 91 described his state as follows:

“Yeah. I want to try to get rid of them. [...] When I am in here I can do that and all this, and I realise what’s going on, but if I was out there and knowing this, I would still be doing the same thing.” (RP 91)
RP 34 felt safe in hospital and stated that, instead of taking the overdose, it would have been better if she had rung her case manager. However she was not certain if she would think of this whilst she was feeling overwhelmed by the voices. (RP 34)

Five of the seven were admitted to a psychiatric ward and the other two were discharged into the care of their families.

**In summary** the participants in this group were young adults who all had an Axis 1 diagnosis, which had impaired their functioning in the weeks leading up to the attempt. Most of the participants in this group reported their childhoods as stable. Those who reported violent behaviour stated that this had started after the onset of their illness. Most of the participants in this group were abusing drug and alcohol and all stated that this was to deal with the symptoms of their illness. Most of the participants in this group had previously attempted to harm themselves, and all of these attempts were made when they were in a state of confusion. All were dealing with social issues but these are related to their general functioning and illness. The actual attempt was impulsive, and was either made in the confused state of their illness or to stop the symptoms/voices relating to their illness. None of the participants were suicidal at the time of the interview and the distressing presence of the voices had disappeared. However the issues relating to their illness were still present. Most of the participants in this group were admitted to the psychiatric ward. The following vignette illustrates this group.

*Pete:*

Pete, a 21 year old man, had been functioning well up until the age of 17. He had been getting good grades at school and had many friends. At the age of 17 his grades started to drop and he had difficulties relating to his friends. Since that time he had been less able to function and was unable to work. He had also started to hear voices and was diagnosed with schizophrenia. At the time of his deliberate self harm attempt he was living in a refuge and was unable to work because of his illness. On the day of his attempt the voices were more pressing than usual and he had been trying to distract himself all day to stop the voices but had been unable to do so. That night he took an overdose to try to stop the voices as he felt that they were attacking him. The next morning in the hospital the voices were still there but they were not overwhelming as they had been the previous night. In addition he felt safe in the hospital. He did not want to take another overdose but was uncertain how he would deal with the voices if they overpowered him again in the future.
**Acute: Social stressors (n=21)**

There were 21 participants in this group. This group was subdivided into those who had made an impulsive attempt and those for whom the attempt was not impulsive.

**Acute: Social stressors - Impulsive**
The participants who had made an impulsive attempt as a reaction to social stressors were subdivided into two subcategories: those who felt overwhelmed by the stressors; and those who attempted to gain control.

**Acute: Social stressors - Impulsive (Overwhelmed by Social Stressors) (n=10)**

*Demographics*
The participants in this group were mainly over the age of 24 and most of the participants in this group were aged between 40 and 54 (n=7). Three were male and seven were female.

*Risk factors*

*Mental illness*
Nine out of the 10 participants in this group had an Axis 1 diagnosis. These were mainly adjustment disorder (n=8) and partially treated major depression (n=1). Adjustment disorder, according to the DSM IV is defined as an acute reaction to stress. It resolves after the stressful event has passed and is not likely to become chronic or impair functioning on an ongoing basis (American Psychiatric Association, 2000). One person also had an associated anxiety disorder. None of the participants in this group had an Axis 2 diagnosis.

*Childhood experiences*
Only two participants in this group reported that they came from a chaotic family background and/or had suffered from abuse throughout their childhoods. In both cases their parents also abused alcohol. However, both participants claimed that this childhood experience did not particularly influence their general functioning.

*General functioning*
The participants in this group functioned well throughout their lives. None described their lives as being chaotic, and all were able to work and maintain good relationships. None reported having difficulties with their anger, violent behaviour, gambling or having a criminal history. All described themselves as feeling in control.
of their lives and having good self-esteem and setting high standards for themselves.

For example:

“But as I said, I’d never ever, go back to that, let that happen again. I’ll always be in control from here on. I might sound hard and everything, but I’m going to be in control.” (RP 73)

“I’ve always had very high self esteem. I’ve always set big goals for myself and if I don’t achieve those goals then I’m a little bit hard on myself.” (RP 76)

These descriptions could be interpreted as an indication of a strong internal locus of control. Internal locus of control is defined as when the perception of control over an event rests within the person. Locus of control was not investigated in this study and this needs to be interpreted with caution, however the impact of this will be discussed further in Chapter 8.

Most of the participants (eight of the 10) in this group did not have any problems with drug and alcohol abuse. The two who did stated that they had only started to drink a few months prior to their attempt in order to cope with their social stressors. Both described their alcohol use as a coping mechanism for their stressors.

Previous attempts
Almost half of this group (four of the 10) had made previous attempts to harm themselves in the past. All of these attempts were made under similar circumstances when they were experiencing difficulties with social stressors.

Circumstances of the attempt
All of the participants in this group reported a large number of stressors just prior to their attempt, and for all the decision to harm themselves was made impulsively. All had thought about it for less than 20 minutes before the attempt, namely: Five to 10 minutes (n=5), less than five minutes (n=3), and 10 to 20 minutes (n=1). All stated that they had not thought about harming themselves in the week prior to their attempt.

Psychache
For all of the participants in this group the attempt was a direct response to social stressors. In all cases they described themselves as feeling overwhelmed by their stressors. Almost half of this group (four out of ten) first tried to drink alcohol to calm themselves down, and when this did not work they took an overdose. The remainder attempted to overdose in order to deal with their stressors. However, both groups
described their attempt/drinking as being outside of their control. They felt that the stress had ‘clouded’ their thinking. For example:

“It’s like a big saucepan of stew going round and round and round, all in one way, and then all of a sudden something just happens and then it goes around in every different way, and you can’t get out of this saucepan of soup. You’re there and all you can see is this hole in the bottom, and that’s where you want to dive to, down there. Yeah, [laughs] that’s the best way I can describe it, anyway! (RP 73)

“I don’t even know what made me open the drink. It’s always in the fridge. And I just started drinking […] and suddenly something popped [and I took the tablets].” (RP 68)

As previously noted all of the participants in this group described their attempt as being a way of coping with their stressors. The attempt was experienced as being outside of their control. All felt overwhelmed by their stressors and did not feel that there was any other way out of their mental state. Below are some examples of this process.

“It was just like a paper bag that exploded. […] I just wanted to have peace of mind.” (RP 25)

“It was like – phew! I’ll bottle stuff up, take this bit today, and I’ll put it in the bottle and close it up, I’ll push it down and not talk to anyone about it. And eventually there’s too many bottles there, and one of them’s got to break, and then they all break. So it’s the same […] That was the first time. I can’t explain what happened last night. It was like an easy option, type thing.” (RP 73)

“I didn’t want to kill myself. I just wanted to sleep, basically. Because I get so exhausted, and I hadn’t slept the night before, I just wanted to sleep, get some rest. […] I don’t think of liver damage at the time. I just think of getting away from the situation.” (RP 89)

Those who consumed alcohol prior to their attempt also described feeling overwhelmed by the actual events in similar terms.

The night of the attempt she had been worrying about her stressors and had drunk a bottle of wine over a period of three to four hours. She suddenly started to feel overwhelmed by her feelings and wanted peace of mind and not to think about what was going on anymore. (RP 42)
Impact of the attempt
The actual attempt had a cathartic effect on the mental state of the participants in this group. All reported a marked shift in their mindset the next morning, and felt able to cope with their issues. The attempt appeared to have taken away the emotional impact of the stressors.

RP 73 described her feelings as follows:

“I feel, like, emotionally I think I’ve taken over. I’ve really got the bull by the horns and I know exactly where I’m going and I know what I want. Um, but, physically I feel drained.” (RP 73)

None of the participants in this group were admitted to the psychiatric ward following their attempt.

In summary the participants in this group were in mid adulthood. All had an Axis 1 diagnosis; however this diagnosis was mainly adjustment disorder with depressed mood. None of the participants in this group had an associated Axis 2 diagnosis. Most reported that they had a stable childhood, and all had a good functioning prior to their attempt. None had difficulties with anger or violent behaviour, nor had a criminal history or issues with drug and alcohol. Those who used alcohol had started to do so in order to deal with the social stressors. Those who had made a prior deliberate self harm attempt had done so under very similar circumstances in order to cope with social stressors. All had difficulties dealing with social stressors prior to their attempt and had made an impulsive attempt to have time out from the stressors in their life and/or stressed state of mind. For all the participants in this group the attempt had a cathartic effect on their mental state and all felt that they were able to cope with their issues again the next morning. None of the participants in this group were admitted to the psychiatric ward.

Selena:

Selena, a 48 year old woman, had a successful career and family. She had been experiencing a lot of different stressors in the weeks leading up to her attempt. She had been having conflict with her boss at work, and three weeks prior to her attempt he unfairly dismissed her. She had taken the case to the Equal Opportunity Board. In addition, at home she had been experiencing problems with her husband who was having an affair. Her son had started smoking marijuana, and was threatened with expulsion from school. The day of her attempt she had a fight with her daughter about her wanting to leave school. She took an impulsive overdose in an attempt to
get away from the stress. She had never made an attempt prior to this. The next morning she felt much calmer about her situation and was able to see other solutions to her problems. Her overdose had really scared her and she could not believe the state of mind she had been in the day prior to the attempt.

**Acute: Social Stressors – Impulsive (gain control) (n=3)**

**Demographics**
This group consisted of three males aged between 24 and 44.

**Risk factors**

**Mental illness**
All three in this group were given a diagnosis of adjustment disorder. None of the participants in this group had an associated Axis 2 diagnosis.

**Childhood experiences**
All three described their childhoods as happy. None reported a history of childhood abuse or described their childhoods as chaotic. None reported a parental history of mental illness.

**General functioning**
All three reported functioning well throughout their lives and none reported a criminal history or a history of violent behaviour. However, two admitted that they could have a “bad temper” if things did not go their way. In addition all three described themselves as controlling. These descriptions could be interpreted as an indication of a strong internal locus\(^\text{27}\). The impact of the locus of control on the attempt will be discussed further in Chapter 8. None of the participants in this group abused drugs and/or alcohol.

**Previous attempts**
For all three this was their first attempt.

**Circumstances of the attempt**
All three had thought about harming themselves for less than 10 minutes prior to the attempt and all three stated that they had never thought about harming themselves prior to this crisis. All three were experiencing difficulties with significant others. Two were experiencing a relationship breakdown. All three attempted whilst they were

\(^{27}\) Locus of control was not specifically investigated in this study and needs to be interpreted with caution.
having an argument with the significant other. Only one had been drinking just prior to the attempt. Again the drinking started in relation to the actual stressor.

**Psychache**
All three described their intention as wanting to gain control over the situation. The feelings they described were a mixture of hurt and gaining back control over the situation. For example:

“I half meant it, I half directed it towards her.” (RP 4)

“[I was] more upset and sad that she was going to leave [...] like I wanted to tell her how much I loved her.” (RP 14)

**Impact of the attempt**
All three had a marked shift in their mindset the next morning and felt calm about the situation. All three felt that they were in control of their situation again.

“No, I just have to let it go and move on. She is not the best thing, [...] that is life. When I look at it now, I think, ‘yeah he has got her now’”. (RP 14)

RP 45 stated that he felt stupid about his “actions” and felt that he has “ambitions I still want to fulfil.” (RP 45)

RP 4 felt that the situation was resolved as his girlfriend had come back. (RP 4)

**In summary**, although there are only three cases in this group they appear to form a discrete cluster. All three had a diagnosis of adjustment disorder. Although none were given an Axis 2 diagnosis, they each described themselves as being controlling. All had a good functioning prior to their attempt and none had problems with drugs or alcohol. All attempted in the middle of a fight and described their intent as wanting to gain control over the situation. All three had calmed down the next morning and had a marked shift in their mental state. None of them were admitted to a psychiatric ward. The following case vignette illustrates this group.

**Charlie**:

*Charlie, a 32 year old man, had been an only child. He ran his own marketing business and liked to be in control of things and at times he would lose his temper when things would not go exactly his way. He had been going out with his girlfriend for 7 months. They had been fighting in the week leading up to the attempt. The day of his attempt she told him that she wanted to leave him. He attempted to hang*
himself in the middle of the fight. He half meant to die and half wanted to show her how serious he was about her. This was his first attempt to harm himself. The next morning he felt calm about his attempt and he was back with his girlfriend. He stated that he would never attempt to self harm again.

**Acute: Social Stressors - Non Impulsive (loss of self) (n=8)**

**Demographics**
There were six females and two males in this group. The age range of this group was 17 to 65 and over. Half of this group was under the age of 34 (n=4) and half over the age of 35 (n=4).

**Risk factors**

**Mental illness**
All eight participants in this group had an Axis 1 diagnosis and these were mainly depressive disorders which included: adjustment disorder (n=5), major depression (n=2) and dysthymia (n=1). Half of this group (n=4) also had an associated Axis 2 diagnosis [borderline (n=2) and dependent (n=2)].

**Childhood experiences**
Because of their mental state at the time of the interview, in four cases the childhood experiences were not explored and therefore the trends observed need to be interpreted with caution. However it appears that their childhood experiences were mostly without abuse as more than half (n=4) described their family of origin as stable. Only one person explicitly described their childhood as being chaotic (unknown n=3).

None of the participants in this group described their lives as being chaotic and all stated that their functioning had been good throughout their lives. All had experienced a drop in their functioning in the weeks prior to their attempt. All described difficulties functioning at the time of their attempt. None stated that they had problems with anger, violent behaviour or gambling, nor a criminal history. None had a history of drug and/or alcohol abuse.

**Previous attempts**
Half of this group (n=4) had made previous suicide attempts. All four had made these attempts in relation to the current crisis and none had made an attempt prior to this current crisis.
Circumstances of the attempt
All had experienced social stressors in the weeks leading up to the attempt. These stressors were mainly: relationship breakdown (n=6), work (n=1) and family (n=1). All of the participants in this group experienced feelings of depression which they attributed to the stressors they had been experiencing.

All eight had thought about harming themselves for some time before acting on their impulse. Four had thought about it for longer than three hours. Only one person had thought about the act for less than 30 minutes. In this instance the actual attempt appeared to be impulsive, though he had thought of harming himself on different occasions in the week leading up to the attempt.

Seven did not attempt under the influence of alcohol. The person who had attempted under the influence of alcohol had been drinking because of the relationship difficulties and had also thought about harming himself prior to the actual attempt.

Psychache
All eight participants described their attempt as being linked to their depressed feelings about their situation and the perception that there were no other options available to them. All felt that they had lost themselves. Below are some examples to illustrate this concept.

“I do not know who I am anymore”. (RP 20)
“I do not want to continue living by myself and thought why should I continue”. (RP 58)

The description of a loss of self could be interpreted as an indication of a strong external locus of control. A person who has external locus of control attributes such control to external agencies such as luck or some powerful other person or force. Again this need to be interpreted with caution as locus of control was not investigated in this study.

Behind the actual intent was a mixture between the feelings of hopelessness about their lives, their feelings of having lost who they are, having no power to improve their situation, and a desire to communicate these feelings to the significant other.

All reported being overwhelmed by their feelings and feeling hopeless about their lives, and could not see any other way out of their situation. For example:

“I can’t get away from him. If I am dead he can not touch me anymore. He can never hurt me again, he can never bother me and I feel like I would do anything to make him
stop. I cannot get rid of him and I cannot get rid of me. And I feel like we are locked in this dance to the death until one of us dies and it is not going to be him. He is too stubborn so then it is me. [...] I was just hoping and praying that I just could go to sleep and not wake up.” (RP 23)

“She’s taken my heart, she’s killed me [...] I had those intentions all day. It felt right when I was leaving to go out, I just, like, real calm. It felt right. My parents they went to bed, they weren’t happy, especially because I was going out, but that felt right too, you know?” (RP 59)

Impact of attempt
Seven participants were still felt like harming themselves at the time of the interview. All seven expressed the feeling that if they were to go home they would make another suicide attempt.

“I am pissed off that I did not die” (RP 20)
“I feel like I want to go home and start all over again.” (RP 23)
“Yeah, I will sit down and do it [attempt] all over again.” (RP 43)

The one person who stated that she was glad that she had survived at the time of the interview was only interviewed three days after the attempt. She had consistently refused to talk to the psychiatric registrars in those 3 days and stated that at that time she still wanted to die. However three days after the attempt she was glad that she had survived and was making plans for the future.

Five were admitted to the psychiatric ward.

In summary all the participants in this group had an Axis 1 diagnosis of depression. Their depressed feelings had started after they had been dealing with a social stressor (mainly a relationship breakdown). All reported that these depressed feelings had been present for a few weeks leading up to the attempt. Half of the group were also given an Axis 2 diagnosis of borderline and dependent personality disorder. All of the participants in this group described their functioning as good and all had experienced a drop in their functioning when the social stressors had started. None of the participants in this group reported violent behaviour, a criminal history or drug and alcohol use. Those who had made a previous attempt had done so in the weeks leading up to the index attempt. None had attempted prior to the start of the
social stressors. All had been thinking about their attempt for a long time before acting on these thoughts. The participants in this group described a loss of self and felt that life was not worth living because of the social stressors they were dealing with. All were still feeling similar feelings at the time of the interview and five were admitted to the psychiatric ward. The following vignette further illustrates this group

Heather:

Heather, a 37 year old female, had been working as a hairdresser most of her life. She had been married to her husband for 12 years. They had been experiencing relationship difficulties in the weeks leading up to her attempt. In these weeks Heather had been having trouble concentrating at work and had lost interest in doing things. The day before to her attempt her husband told her that he was going to leave her. She had been feeling hopeless about her life and felt that she would never have the same quality of life without her husband. She had been thinking of ending her life all day. She took an overdose and rang her husband to say goodbye. He was worried about her and called an ambulance. The next morning she was still feeling depressed and hopeless about her situation and still wanted to die.

Conclusion: Acute groups

This chapter reported on the characteristics of the acute groups. The acute groups were characterised by participants who described their past functioning as good and experienced a drop in their functioning at the time of the deliberate self harm attempt. When analysing the circumstances of the actual attempt, distinct groups emerged, each of which had different characteristics. The groups described in this chapter were: Psychiatric condition (depression and schizophrenia) and Social Stressors - Impulsive (overwhelmed and gain control) and Social Stressors – Non impulsive. In the next chapter the chronic groups will be described.
Chapter 7: Stage 4 – Chronic groups

The previous chapter described in detail the characteristics of the acute group. This chapter will report on the characteristics of the Chronic group. The Chronic group is characterised by the longstanding nature of their difficulties described at the time of the deliberate self harm attempt. The chronic group can be subdivided into subgroups with the following characteristics: those with longstanding drug and/or alcohol issues (Under Influence and Withdrawal) and those reacting to social stressors – impulsive (Low Self Worth and Self Hatred) and non-impulsive (Disconnection). Each group will now be discussed in detail. This chapter concludes with a summary of the characteristics of the acute and chronic groups and an overview of risk factors for each subgroup.

Chronic: Drug and/or alcohol abuse (n=15)

The participants in this group all had very similar backgrounds. The group was divided into subgroups in relation to impact the different drugs had on the attempt. The general characteristics of this group will be described first and then the differences regarding to the impact of these drugs on the mental state will be explored.

Demographics

There were twelve males and three females in this group. Nine participants were aged between 35 and 44, four were under the age of 34 and two were aged between 45 and 54.

Risk factors

Mental illness
Almost ninety percent (n=13) in this group were given an Axis 1 diagnosis. These were mainly depressive disorders, namely adjustment disorder (n=9), drug induced psychosis (n=2), dysthymia (n=1) and paranoid depression (n=1). Four also had an additional diagnosis of PTSD and anxiety disorder (n=2). The majority (n=9) did not have an associated Axis 2 diagnosis. The six who did have an Axis 2 diagnosis were: antisocial (n=5) and dependant (n=1).

Childhood experiences
Ten of the 15 participants in this group described their childhoods as being chaotic (4 were unknown). Only one person stated that her family of origin was caring and
loving. Thirteen reported a parental history of alcohol abuse and one reported a parental history of depression.

**General functioning**
All 15 described their lives as being chaotic and reported difficulties maintaining close relationships and/or work. None in this group described their general functioning as good. Twelve out of the 15 stated that they had problems with their anger and 11 described violent behaviour. Twelve also had problems with gambling and eight had a criminal history. All 15 in this group had problems with drugs and/or alcohol. Most of the participants used a combination of drugs. These were mainly alcohol (n=14), marijuana (n=11), speed and heroin (n=5), prescription (n=3) and methadone (n=2).

**Previous attempts**
Most of the participants in this group (n=14) had made previous attempts. Thirteen out of this group had attempted within similar circumstances. They described the pattern of their attempts as either continual (n=7), or when they were in a similar crisis (n=3). Two stated that they only attempted when they were experiencing an episode of mental illness. Both of these cases had a diagnosis of drug-induced psychosis; however because their thinking had changed as the drugs wore off, they were included into this group and not the psychiatric group.

**Circumstances of the attempt**
Eleven of this group were experiencing social stressors prior to their attempt. Two participants were experiencing a relationship breakdown. The circumstances of the attempt differed according to the drugs that were used. Three main scenarios emerged from this set. These were as follows:

**Chronic: Drug and Alcohol Abuse - Impulsive (under influence of alcohol) (n=10)**
Seven out of the 10 experienced social stressors prior to their attempt. Six of these started drinking as a result of these stressors. All 10 described their drinking as a mechanism to cope with their feelings, and as a means of not having to think about their problems.

“I’m not quite sure [why I started drinking], probably to distract myself. When I start drinking I don’t feel anything. And the next thing I know, like, I’m asleep and it’s the next day.” (RP 78)

“I am drinking beer, you know, because I have been feeling depressed, you know? Then I start drinking faster and faster and then I look in the mirror and I am talking to myself and think about a way to kill myself. The feelings
are strong, they are everything. All the time I feel too much.” (RP 74)

“It just comes from, I do not know, depression? Maybe thinking about it, maybe being home by yourself, nothing to do, drinking alcohol and that is probably how the ball starts to roll. And then I start to feel sorry for myself and down goes 60 to 80 tablets”. (RP 8)

All the participants in this group had thought about the attempt for less than 30 minutes before acting. The majority (n=6) had though about it between 5 and 10 minutes, two had though about it for less than five minutes and the remaining two had thought about it between 10 and 30 minutes. Seven of the participants in this group stated that they were too drunk to remember what they did or felt at the time of their attempt. All stated that they were not feeling suicidal prior to their drinking.

Some comments from this group included:

“To tell you the truth I got no knowledge. I do got knowledge of taking the medication, but having knowledge on what made me do that. I do not know, and it has happened a couple of times. And I just try to find the right answer to ‘why?’” […]“Sometimes I could just be sitting there and I just feel so disgusted with my life, and the answer could be there. And I think to myself ‘I do not really want to be on this planet anymore, I just want to end it, there is nothing here for me.’ but there is! And I should not be doing these sorts of things.” (RP 8)

“I am not sure what happened last night, I only remember that I took tablets […] I can’t remember, I can’t remember much about last night.” (RP 7)

The other three described their attempt as a response to wanting to have time out from the way they had been feeling or general feelings that life was too difficult.

“I took some tablets and had some alcohol in me system. I was also having a lot of problems […] it was just the build up […] I just wanted to get out of the thoughts for a while.” (RP 24)

“I was homeless. Had nowhere to go. Just I felt that I wasn’t a part of society. […] I think it’s human nature to want to die.” (RP 78)

Seven of the participants in this group had a marked shift in their mindset at the time of the interview. Three participants were experiencing similar feelings to those prior
to their attempt although the impulse to harm themselves had disappeared. Two of these three were still under the influence of alcohol at the time of the interview. All of the participants in this group attributed their depressed feelings to their drinking. For example:

“It is the big thing when I do not drink, I am so positive, I am out doing things and I think a lot clearer, you know. I am doing things, I am happy with life.” (RP 8)

“I only act on it when I’m drunk. When I’m straight I think about it sometimes. You know, it’s not a good way to live.” (RP 61)

Interviewer: When you’re not drunk, have you ever had thoughts about wanting to kill yourself?

RP: No! No, no, no, no! (RP 96)

Chronic: Drug and/or Alcohol Abuse – Impulsive (drug induced psychosis) (n=2)
Two participants in this group were under the influence of speed or marijuana and had developed a drug-induced psychosis, which lifted once the drugs had disappeared from their system. Both participants had thought about the attempt for less than five minutes prior to acting and both stated that they had not thought about harming themselves prior to this. Each had a marked shift in their mental state at the time of the interview. However, it is important to note that one case had sustained brain damage as a result of the attempt and, because of the physical injuries obtained, could not be interviewed until three weeks after the attempt.

Chronic: Drug and/or Alcohol Abuse- Non-Impulsive (drug withdrawal) (n=3)
Three participants were withdrawing from a speed/heroin binge at the time of their attempt. Their presentation was different from the ones described above. Their attempts were far less impulsive. All three had been thinking about harming themselves in the week leading up to the attempt. Two had been thinking about harming themselves for over three hours prior to their attempt. For one person the actual attempt appeared to be impulsive and was triggered by a social stressor. However he stated that he had been thinking about harming himself for a long time and that the trigger was just the final straw. All three expressed feelings that life was too difficult for them. All three described a sense of relief when they decided to end their lives.

“Oh, yeah! I felt happy. And, um, happy that I made a decision I’m going to go and do it and, yeah, it’s a relief.”
(RP 94)
“I felt calm [after I made the decision].” (RP 51)

All three were still feeling suicidal at the time of the interview and were still withdrawing from the drugs.

**Interviewer:** How did you feel about the fact that they rang the ambulance and –

**RP:** “Angry. I wanted to be dead.” (RP 94)

**Interviewer:** Are you still in the same state as when you went into the garage?

**RP:** “Pretty much. [...] As soon as I get out of here I’m going to go and do it again. I mean, when your mum tells you something like that, it’s not real good.” (RP 51)

**In summary** most of the participants in this group were males aged between 35 and 44. Most had an Axis 1 diagnosis of adjustment disorder and the majority did not have an Axis 2 diagnosis. Most described their childhoods as being chaotic and had difficulties functioning throughout their lives. The majority described having problems with anger and violent behaviour, and half of this group had a criminal history. All had problems with drugs and/or alcohol and most of the participants used a combination of drugs. More than 90% of this group had attempted to harm themselves in the past and all had done so while under the influence of alcohol. All of the participants in this group were under the influence of drugs and/or alcohol at the time of their attempt.

The timing of the attempt varied according to the drugs used. Those who were under the influence of alcohol had made an impulsive attempt. None felt suicidal prior to their drinking and most stated that they were too drunk at the time of the attempt to remember what they intended. Seven had a marked shift in their mindset. Only one person was admitted to the psychiatric ward. Those who exhibited withdrawal symptoms from speed or heroin described their attempt as more being more deliberate, and had been thinking about harming themselves for quite some time. All felt that life had become too difficult. All were still feeling the same the next morning and were admitted to the psychiatric ward. Those who attempted in the drug induced state of confusion, did so on impulse. Where the effects of the drugs had disappeared at the time of the interview, so had the impulse to harm themselves. The following two case vignettes further illustrate these groups.

_Eddie_
Eddie, a 27 year old male, came from a very chaotic family background. Both his parents had abused alcohol and marijuana and his father was often violent. He had started drinking at the age of 13 to cope with his feelings. He also smoked marijuana. He had been unable to work in one job for more than two months and was on unemployment benefits at the time of his attempt. He had one daughter but had not seen her for a long time. On the night of his attempt he was alone at home and was feeling depressed about the fact that he had not seen his daughter for a long time. He then started to drink. He attempted to hang himself while he was drunk and stated afterwards that all was a bit hazy and he did not remember what went on in his mind. He had made three previous attempts under similar circumstances. The next morning, after he sobered up, he felt better and attributed his mental state to the alcohol he had drunk and did not think that he would ever make an attempt again in his life.

Ernest

Ernest, a 37 year old male, came from a very chaotic and abusive background. His father often abused alcohol and was violent towards him and his brothers. He had been drinking alcohol since the age of 14 and had started to take speed at 16. He had never been in one job for longer than three months. He was not in a relationship. Three weeks prior to his attempt he had been on a big speed binge before running out of money. After this binge he had started to feel depressed. He wanted to have a relationship and to be able to work, but he felt that he would never be able to do so. He had thought about killing himself for two days and had waited for the perfect opportunity. He tried to hang himself but was discovered by his brother. At the time of the interview he was still feeling very down about his life and still wanted to die, but at the same time he was willing to be admitted to a detoxification unit.

**Chronic: Social Stressors - Impulsive (n=8)**
The group social stressors – Impulsive was subdivided into Low Self Worth and Self Hatred.

**Chronic: Social Stressors – Impulsive (low self worth)**

**Demographics**
The group consisted of five males and three females. The ages of the participants ranged from 17 to 64, with half of this group being under the age of 34.
Risk factors

Mental illness
Seven were given an Axis 1 diagnosis. These were mainly depressive disorders including adjustment disorder (n=5) and heroin induced mood disorder (n=1). In addition one person was diagnosed with an anxiety disorder and one with PTSD. Six had an associated Axis 2 diagnosis. These were dependant (n=3), anti social (n=2), and borderline (n=1).

Childhood experiences
The childhood experiences of members of this group were chaotic and abusive. Four reported a history of childhood abuse and six reported that their family background were very chaotic. They described violence within the family home and described their parents have difficulties maintaining relationships and/or employment. Six reported that their parents abused alcohol.

General functioning
All of the participants in this group had difficulties functioning throughout their lives and all were leading chaotic lives. All described difficulties maintaining meaningful relationships and/or stable employment. Six reported that they had problems with their anger and seven described violent behaviour. Half (n=4) also gambled, and three had a criminal history.

All eight had issues with drug and alcohol abuse and this was mainly a combination of drugs. Six abused alcohol, five marijuana, three heroin and/or speed and one was also addicted to methadone.

Previous attempts
Six of the eight had made previous attempts in the past and all of these attempts were made when they were in a similar crisis.

Circumstances of the attempt
All eight had experienced a social stressor just prior to their attempt, namely a fight with a significant other. All eight had thought about the attempt for less than 10 minutes before acting on this impulse and six of these had considered it for less than five minutes. None of the participants in this group had thought about harming others.

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28 For three participants the childhood experiences were unknown
29 For two participants the family background was unknown
30 For two cases the parental mental illness was unknown
themselves in the week leading up to their attempt. Six stated that they were under the influence of alcohol when they attempted.

Psychache

All eight felt rejected and hurt by other peoples’ behaviour and wanted to show these people how hurt they were feeling. They all described a mixture of anger and hurt, for example:

Interviewer: Did you want to kill yourself?
RP: “Yeah, after everything I done for her, the car, the job, it just all fell through. Nothing I could do was right. […] Yeah, I was drinking and I took some of the pills and that was out of anger. Because I have hit her before and I will not do it again. I would rather hit something else. […] No, it was out of anger. Not with her, not with them, but with me.” (RP 16)
RP: “She told me to get out of the house and that type of thing and that. And because I have been kicked out of the house and that before, I felt that I had nowhere else to go. So I just went into the kitchen and, first of all and I got the wrong knife and that did not work, and so I went back into the kitchen and got one of the steak knives and inserted into my chest.

Interviewer: And did you want to die?
RP: “Yeah I did want to die. […] I feel really upset and rejected and just stuff like that […] it feels like it is just the easy way out. So then I do not have to worry about it anymore and I worry about what is going to happen in the future type thing.” (RP 38)

“Yeah, because I love him so much and it’s like he doesn’t give a shit about me.” (RP 50)

“Everything! Everyday life! The reason why I did it was to make everybody else wake up and ‘oh shit, K___’s serious here! She’s finally done something, it was stupid of her to do it but, hang on, she’s serious!’ And they still don’t give a fuck, anyway. […]Yeah, I was angry when I took them. […] I was angry because I felt like I was violated. Violated in everything, every way possible that you can think of. For years my body had been violated. I thought, huh! I won’t have anyone else abuse my body, I might as well go and abuse it myself. That’s what I thought about it. Why have everyone else out there abuse you, S? Go and do it to yourself! Show them how much of a fucking idiot you really are! Excuse my language.”( RP 54)

“It’s been an ongoing argument with my partner, you know, there is a lot of hatred there, she was stating her
rights, you know? She wants me out by Christmas, you know? And that’s it [...] That was the thing you know, the final straw, if you like. [...] and I remember, I said you think I’m such an arsehole, you know I supported you and your family for all these years I want to say to you and then the next thing it happened, bang you know [...] I wanted to prove her.” (RP 65)

**Impact of attempt**
All eight participants in this group had a marked shift in their mindset the morning after the attempt. The anger and hurt they had experienced the night before had dissipated. All stated that they would never attempt suicide again, but they appeared to have limited strategies to prevent this from happening. None were admitted to the psychiatric ward.

**In summary** this group was comprised of participants with a range of ages. Most of the participants in this group were given an Axis 1 diagnosis of adjustment disorder. The majority also had an Axis 2 diagnosis. Most of the participants in this group described their childhood experiences as chaotic and abusive, and all reported that they had difficulties functioning throughout their lives and were leading chaotic lives. Ninety percent had problems with violence. Most of the participants in this group also had made previous attempts under similar circumstances, when they felt hurt by other peoples’ behaviour. All eight had a fight with a significant other just prior to this attempt and had thought about it for less than 10 minutes. All stated that they had not thought about harming themselves prior to the fight. Most of this group was also under the influence of alcohol at the time of the attempt. All felt rejected and hurt by the other’s behaviour and wanted to show them how hurt they were feeling. All eight had a marked shift in their mindset the next morning and none were admitted to the psychiatric ward. The following vignette further illustrates this group.

**Harry:**

*Harry, a 35 year old man, came from a very chaotic family background. He had three half brothers and two sisters. His step-father was very violent and had a problem with alcohol. His mother found it difficult to cope with things and often smoked marijuana to be able to deal with her emotions. From a very early age Harry found it difficult to deal with his anger and often had very violent outbursts. He started to smoke marijuana and drink alcohol at the age of 11 and left school at the age of 14. He had several run-ins with the law and at the age of 21 was convicted to three months in prison for malicious wounding. He had broken somebody’s jaw and ribs in a fight*
when he was drunk. He had never been able to work and at the time of his attempt he was on Government sickness benefits. He had different relationships throughout his life, all of which had been very violent. He had started seeing his current girlfriend three months prior to his attempt. Their relationship was difficult and they often had very violent fights. On the day of his attempt he had been drinking all day. That night he and his partner had another fight where she told him that she was going to leave him. In the middle of this fight he took a knife and stabbed himself. He wanted to show her how he was feeling. He had tried to harm himself on five different occasions in his life, always under similar circumstances. The next morning the crisis was resolved and his girlfriend had decided that she would come back to him. He was feeling calm about what had happened and thought that he would never do something like this again and he refused to have any help offered to him. He came to hospital six months later after he had another fight with his girlfriend. This time he had tried to hang himself.

**Chronic: Social stressors - Impulsive (self-hatred) (n=10)**

**Demographics**
This group was composed of 10 participants ranging in age from 17 to 54. Five were male and five female.

**Risk factors**

**Mental illness**
The psychiatric diagnoses associated with this group are adjustment disorder (n=7), including one with an associated diagnosis of anxiety disorder (n=1). Three did not have an Axis 1 diagnosis. All 10 participants in this group also had an associated Axis 2 diagnosis and these were: borderline (n=5), anti-social (n=3), narcissistic (n=1) and dependant (n=1).

**Childhood experiences**
All 10 reported a history of childhood abuse, and described their childhoods as being chaotic. All the participants in this group also stated that their parents abused alcohol.

**General functioning**
All reported difficulties functioning throughout their lives and described their own lives as being chaotic. All had issues with anger, and exhibited violent behaviour which had been present throughout most of their lives. Seven also reported a criminal history as well as issues with gambling.
All had issues with alcohol abuse and all used a combination of drugs: nine used alcohol, 10 marijuana, nine speed and/or heroin, seven prescription drugs. Three were on a methadone program.

**Previous attempts**
All had made several previous deliberate self-harm attempts. Only one person had made less than three attempts. The others had made numerous attempts throughout their lives and appeared to utilise self-harming behaviour as a normal coping mechanism in response to stress.

**Circumstances of the attempt**
All 10 had a social stressor just prior to this attempt and made the decision to harm themselves impulsively. All attributed the attempt to a social stressor, however the attempt was made to escape the underlying feelings of self hatred rather than the actual social stressor. The stressors had triggered underlying feelings of hopelessness. All thought about it for less than 20 minutes, with half of this group reporting having thought about the attempt for less than five minutes. Four of the 10 had thought about the attempt between five and 10 minutes and one had thought about the attempt between 10 and 20 minutes. One participant described the impulse as follows:

“I just get a sudden thought of doing something. And then I’ll do it and then five minutes later I’ll think, ‘Oh shit, why did I do that?’” (RP 69)

**Psychache**
The participants in this group all expressed difficulties dealing with the stressful situation they were presented with. All felt that they had run out of options. For all of the participants in this group it was the stressor in combination with other issues in their lives that influenced their attempt. The Psychache in this group was associated with their self hatred. Then they felt that the issues that overwhelmed them were a confirmation of that their lives were not worth living. All the participants in this group expressed marked feelings of hating their lives. For example:

“I have planned to kill myself all my life because life is shit” (RP 27)
“Because life is shit” (RP 36)
“I am sick of living the life I live.” (RP 66)
“And I thought ‘why don’t you just finish it, and get on with it?’ […] I felt like I sort of euphoria, thinking ‘yeah,
that is a solution to a problem!’ Because my whole life has been a series of disappointments, heart aches, traumas, my whole life, from nearly the time I was born.” (RP 40)

“I wanted to burn from inside. Harm myself. Punish myself for letting myself get into such a predicament where I hated being overprotective of S_____ [Partner].” (RP 80)

A large part of the intent was to have time out from their own lives and to end the pain. For example:

“When I did die, it was a lovely place to be at, I’m telling you. It’s just like you’re running through a field of daffodils or something. There’s nothing there to harm you and there’s, like, nobody’s around, you can’t see nobody – it’s just, you had no problem, everything you wanted was there. But there was nothing there.” (RP 71)

“What am I here for? It’s not just that, you know. That’s one thing. I’m just a really emotional person and a lot of things have happened to me in my lifetime, you know? I’ve been molested when I was a kid, I’ve been raped God knows how many times, I’ve been bashed by more men than women, you know? I’m sick of it, I’m really sick of this world. It’s unfair, it’s cruel, nothing good happens in it. Just misery, misery. You turn on the TV, do you see anything nice?” (RP 95)

“When I take tablets, I think I do, or I take tablets and I get so out of it, so that I do not have to put up with the pain. […] It’s I think, it is something that you want to kill pain. It is like a needle, it is like an injection and participants that do want to kill themselves will kill themselves.” (RP 32)

**Impact of attempt**

The following morning after the attempt half of this group (n=6) reported a shift away from the impulse to harm themselves; However, even though there was a shift in their mindset, they all stated that they would probably make another attempt in the future, and that they were still feeling quite ambiguous about their lives. The other half (n=4) were still feeling suicidal the next morning and these four were admitted to the psychiatric ward.

The following are quotes from those who had a shift of mindset:

“At the moment I am not in the mood to go through what I went through yesterday. I am just not in the mood for it, right. You know, I am not saying that six weeks, maybe six months, maybe six years down the track that I am not going
to hurl myself off the Harbour Bridge or the Gap or whatever, I can’t give that sort of guarantee.” (RP 40)

“How do I feel about it? Um, a bit cranky in a way, because the thoughts are still there, you know? But, not really, at least the kids do want to see me alive. I’m not dead, you know? […] In other words, I’m looking forward to more and better things? Yeah, I am.” (RP 71)

Others reported feeling the same at the time of the interview:

“[I am feeling] scared, I think that the job should have been finished. And if I have to live and eat like this I would have preferred to go over the edge. I don’t think I would do that (sighs) I’m still here.” (RP 80)

“Yeah, I’m still feeling the same. I don’t feel angry. I feel depressed. I feel hurt. […] I want to die but I haven’t even got the guts to do it properly. So I keep causing shit and wasting time and space for everybody [crying]. Because I haven’t got the guts to do it properly.” (RP 95)

In summary this group is comprised of participants with a range of ages. Two thirds of the participants in this group had an Axis 1 diagnosis, mainly of adjustment disorder, and all had an Axis 2 diagnosis. All reported that they had chaotic and abusive childhoods and had difficulties functioning throughout their lives. All members of this group had issues with anger and violent behaviour throughout most of their lives, and two had a criminal history. All misused a combination of drugs throughout most of their lives. Ninety percent of this group had made several attempts throughout their lives. For all, the decision to self-harm appeared to be impulsive, and most often the attempt was done in response to a stressful social trigger. For all of the participants the difficulties coping with different stressors had been present throughout all of their lives. All expressed marked feelings of self-hatred, and the actual attempt was described as a way to escape these feelings. For two thirds of this group the actual suicidal impulse had disappeared the next morning and they had mixed feelings about their lives. Four participants were admitted to the psychiatric ward. The following case vignette further illustrates this group.

Cassandra:

Cassandra, a 29 year old woman, came from a very abusive background. Her father misused alcohol and had abused her sexually on several occasions. Her mother had also been violent towards her. She had been Ward of the State at the age of eight.
She had started to abuse different drugs at the age of 11 and was addicted to heroin at the age of 16. At the age of 24 she was started on the methadone program. She felt that she was unable to function without the methadone as it dulled her emotions. She had never been able to work and at the time of her attempt she was on Government sickness benefits. She had been in different abusive relationships and had two children from these. Both her children had been made Ward of the State. She often had anger outbursts and could easily become violent. She had made numerous self harming attempts, her first one at the age of 14. At the time of the attempt she was living on the streets. The day of her attempt she had lost her wallet and felt overwhelmed by her feelings and took the overdose to have time out from her feelings. The next morning she was not feeling suicidal anymore, and did not want to talk about what was going on for her because she felt that talking about things did not help her. However, she stated that she would never attempt to harm herself again. She came back to the emergency department two weeks later under similar circumstances.

**Chronic: Social stressors - Non-Impulsive (disconnection) (n=20)**

**Demographics**
Members of this group were all female and predominantly composed of younger women (13 between the ages of 17 and 24, and six between the ages of 25 and 34).

**Risk factors**

**Mental illness**
Thirteen participants in this group were given an Axis 1 diagnosis. These were mainly depressive disorders: adjustment disorder/depression not otherwise specified (n=7), dysthymia and melancholic depression (n=4), postnatal depression (n=1) and major depression (n=1). One person also had an anxiety disorder (n=1). Twelve participants also had an Axis 2 diagnosis and these were mainly borderline (n=11) and dependant (n=1).

**Childhood experiences**
Eleven reported a history of abuse, and for nine of these the abuse had happened throughout their childhoods. For most of this group the abuse had occurred outside of the family of origin and most of this group described their childhoods as stable. Only three in this group reported that their childhoods had been chaotic. Of note is that 13 (65%) of this group felt that their parents were emotionally distant. A little less than
half of the group (n=8) reported a parental history of mental illness. These included depression (n=3), PTSD (n=1), and drug and/or alcohol abuse (n=3).  

**General functioning**  
All 20 women described feelings of disconnectedness with the world and felt that life had little meaning. They all reported that they were functioning on the surface but were unable to cope with their emotions. Some examples include:

> “Inside I am just a hollow shell. My heart may be beating just to pump the blood around my body but that is all that it does.” (RP 55)

> “It does not matter, it [life] is inconsequential, in the whole scheme of things. Who cares, it is - what do they say: a drop in the fucking ocean. It does not matter.” (RP 53)

None of the participants in this group were leading a chaotic life, none reported violent behaviour, none had issues with gambling and none reported a criminal history. Three quarters of this group (n=16) did not have a drug and/or alcohol issue. The four participants who did mainly abused alcohol (n=3), marijuana (n=1) and prescription drugs (n=2). All four stated that they abused alcohol to deal with their feelings of disconnectedness.

**Previous attempts**  
Twelve had made previous deliberate self harm attempts. For most these attempts were made under similar circumstances. Five made repeated attempts throughout their lives (more than five attempts) and five had made attempts when they were in a similar crisis.

**Circumstances of the attempt**  
Fifteen out of the 20 reported a social stressor (mostly a relationship breakdown) prior to the attempt. However, 14 stated that it was not the social stressors but their feelings of disconnectedness that made them attempt to self harm. It appears that for this group it was not the social stressor as such that caused the attempt, but the emotions it brought up.

RP 92 attempted after she broke up with her boyfriend. She stated that she had been thinking about harming herself for a long time prior to that and that the break-up just confirmed these feelings for her.

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31 The childhood history of three were unknown
RP 49 had broken up with her boyfriend just prior to the attempt. She said: “I was sick of everything. I’m sick to death of everyone doing what they like, they’re living their lives, and I can’t live with mine. […] I have been feeling like that for a while, for ages actually […] . I’d just had enough and the tablets weren’t doing that.”

RP 2 attempted after she had been experiencing relationship difficulties. She did not think that the actual relationship difficulties were the cause of her attempt, but rather that these difficulties confirmed the way she had been feeling.

Psychache
For all of the participants in this group, the feelings of hopelessness had been present for quite some time. Even those who stated that the actual attempt was quite impulsive, the underlying feelings were described as having been present for years. Sixteen had thought about the actual attempt for more than 30 minutes. Thirty minutes to 1 hour (n=5); 1 to 3 hours (n=5) and more than 3 hours (n=6). The intent of this group was mainly to get away from their feelings or the way they had been feeling. They were experiencing confusion and did not know how to handle this confusion. They felt empty inside and did not now know how to deal with these emotions. Participants in this group all expressed a desire to get away. All expressed the feelings that the stressors occurred on top of the way they had been feeling and that they could not cope with this.

“I just wanted to tell God that ‘I do not want to play this game anymore, can you switch it off. I do not want to play this game anymore’ […] I do not want to have the responsibility.” (RP 2)

“It was just basically that – everything that had happened over the last couple of years. I didn’t really think about what was going to happen if I died, what was going to happen, how would everyone feel, I didn’t really think about that, I just sort of thought about what was said to me and things like that. […] Yes. To just get rid of everything, everyone […] Just all the stuff that my dad says to me, like, I’m worthless and ugly and stuff. […] I just wish we could go away. That’s why I did it. Go away.” (RP 79)

“I don’t know. All I just want to do is get away. I start off by wanting to hide, where I don’t want no-one to see me, just under my blankets and hide, in a dark spot, hide, like, don’t want no-one around me, and then after that just – I don’t know. I don’t know, I just want to hide. Just get away from everyone. I want others to understand how hurt
I’m feeling. How – I don’t know. I just don’t want no-one near me. I just want them to understand me, I don’t know. I’m too hurt, I’m depressed, I don’t know what to do. All I want to do is just not be here, I don’t want to be here.” (RP 92)

“I wanted to die because um, I can’t stuff up anymore. […] Mm. Because then I don’t have to worry about everything that he doesn’t want to see me, he doesn’t want to even know me […] [I was] Upset, because I didn’t want to end up here in the hospital like I did last time. I wanted to die because um, I can’t stuff up anymore.” (RP 63)

Three participants reported that they had first started to cut themselves to make their mental pain physical and when this did not work, they attempted to overdose. For example:

“Absolutely, it just distracts you, it really does. It helps a lot in that respect, it is the way it just brings you back to reality. It is just like I have done this thing that is physical, rather then just something that you can’t put into words in your head […] I know about dosage and stuff. And I knew that I just took enough to take myself out of it, I did not really want to kill myself.” (RP 10)

**Impact of attempt**

Eighteen participants did not feel suicidal the next morning, though fourteen still reported that they were still experiencing similar feelings to those they had prior to their attempt. The remaining two still felt suicidal at the time of the interview. Only four women stated that they were feeling good the next morning. For three of these four, it had been their first attempt. It is possible that the feelings of well-being following the attempt were only temporary for these women as most participants in this group had made multiple attempts. Five were admitted to the psychiatric ward. Some comments from members of this group include:

“I don’t know if I will do it again but I will think that I will always have in my mind to end like that, but I do not know if I am going to do it. Because I think there are many ways that I can die.” (RP 13)

“I feel pretty much the same. Because I know I’ll probably do it again. So I really wish I didn’t say that, but it’s the truth. […] I just want to get away from it. Like, I want to deal with it but it’s just too painful.” (RP 63)
A comment from a member of this group that was still feeling suicidal the next morning:

“Like, even if I go home now I’m going to do it again, because I don’t want to live. It hurts too much as it is.” (RP 92)

The following comments are from participants whose thinking had shifted the following morning:

RP: No. [I will not attempt] Not ever again. No.

Interviewer: Why do you say that? I believe you.

RP: Because I hurt my parents a lot. That’s why. (RP 84)

“I don’t know. I feel stupid and dumb. Oh, like my parents are going to keep a close eye on me now. I stuffed up big time. I’ve probably lost my job.” (RP 49)

In summary this group is composed of younger females. Two thirds of this group were given an Axis 1 diagnosis of depression. Even though this group described their functioning as being good, all described feelings of disconnectedness with the world and feelings that life is meaningless. All the respondents had experienced depressive symptoms for some time and had been classified as suffering from mild to moderate levels of depression. In addition two thirds of this group had a diagnosis of borderline personality disorder, and half of this group had reported a history of abuse. The type of abuse reported was mainly single events that occurred outside of the family of origin. Of note is that two thirds of this group described their parents as being emotionally distant. All of the participants in this group described their functioning as good and none had problems with violent behaviour or gambling. The majority did not have any drug and/or alcohol abuse. The attempt itself was not impulsive for participants in this group. Where the actual attempt appeared to be impulsive the actual feelings leading up to the attempt had been present for a long time. The attempt itself was described as a response to being overwhelmed by their feelings, with the attempt being outside of their control. Half of this group had made at least one previous attempt under similar circumstances, and of those most had made more than three attempts. Eighty percent of the participants stated that they were not feeling suicidal at the time of the interview; though, three quarters of these reported that they were experiencing the same feelings of disconnectedness they felt
prior to their attempt. Five were admitted to the psychiatric ward. The following case vignette further illustrates this group.

Amelie:

Amelie, a 21 year old woman, found it difficult to relate to other people, in particular to her parents. She felt that nobody really understood her. She had been feeling disconnected with the world. She often felt overwhelmed by her feelings and did not know how to deal with her emotions. She often felt that even the smallest stressor was too much to deal with, and she did not really understand her feelings. In the weeks leading up to her attempt she had been having troubles with her boyfriend. The day of her attempt they had a fight and he told her that he did not want to see her anymore. She was upset by the break-up and did not know how to deal with her feelings. She was frantic about her emotions and felt overwhelmed by them and just wanted them to stop. She did not want to worry anymore and took an overdose. She had made numerous attempts to harm herself throughout her life, always under similar circumstances. The next morning at the time of the interview she was not feeling suicidal; however she was still feeling confused about her feelings and was unable to rationalise what had been going on for her. She did not feel the fight with her boyfriend was the real cause for her attempt. She could not explain why she had been feeling the way she had been, and thought that she should be able to get over it. Three weeks after this attempt she had been feeling upset after a minor fight with her parents and took another overdose to try to calm herself down.

**Conclusion: chronic group**

This chapter described the characteristics of participants in this study classified as chronic. The chronic groups were characterised by longstanding general difficulties coping throughout life. The attempt was made to cope with these problems. The chronic groups described here were: Drug and/or Alcohol issues (Under Influence, Drug Induced Psychosis and Drug Withdrawal). Social Stressors – Impulsive (Low Self Worth and Self Hatred); and Social stressors - Non-Impulsive (Disconnection)

In addition to the groups that were described in the previous and current chapters, four cases were classified as other. It is possible that these cases are additional groups leading to a deliberate self harm attempt. It is also possible that these cases share a common Psychache with others. These cases are briefly presented below, and will not be explored any further in the context of this thesis.
Other possible groups identified in this study.

Presentation of cases

Epilepsy

RP 11 was a 35 year old female. She described her childhood as chaotic and abusive. She had led a very chaotic life and had difficulties with drugs and alcohol for a long time. She developed several physical illnesses because of her lifestyle. In the year leading up to her attempt she started to have grand mal fits. The day of her attempt she had a grand mal fit and woke up in a confused state. She attempted to harm herself while she was in this state. She was interviewed four days after her attempt, and the effects of the grand mal on her thinking had disappeared. Her feelings of depression and the impulse to harm herself had disappeared. She stated:

“Every time I have woken up from a grand mal my thinking is always, you know it is like the lights are on, but nobody is home or something. And I do not understand what anybody says to me and it is just like talking to somebody with dementia or something. And when I had a few fits, and they are not grand mal or something, I always wake up really agro.” (RP 11)

Two very similar cases presented throughout the study but could not be interviewed because of cognitive impairment. These two cases both had developed epileptic seizures after abusing different drugs throughout their lives.

Wanting to be Admitted

RP 75 was a 32 year old male who stated that he had taken a very large overdose of his medication, however there were no physical symptoms. His story was very convoluted and contained a lot of contradictions. At the time of this attempt he was experiencing problems with housing and it is likely that his attempt was an effort to be admitted to the psychiatric ward. Even though this case was seen to be manipulative, it has to be noted that this person did have a lot of different social issues and felt unable to deal with them. He came from a chaotic and abusive background and had difficulties with drugs and alcohol. He had a marked hatred of himself. The issues he was facing were very similar to those identified within the Self Hatred group, and the hospital was the only place he could think of that could help him solve his problems. He stated:

“I don’t know, I was at a loss as to how to go. It’s like I picked up the ball and I ran with it all the way down to the end field, now all I’ve got to do is work out wherever I was going to make a touchdown, or whether or not I was going
to make an pass – and, like, well, I made a touchdown by going to the hospital, and then they, like, transferred me to Cumberland [a psychiatric institution].

First I tried to – I don’t know, I really can’t explain it any more than saying I was trying to get accommodation or look for a place to stay out that way. Um, and then it just went from who gives a fuck, it was like, I don’t care anymore. I just want to kill myself. And so, um, I guess I staved off putting a knife through my heart like I was going to.” (RP 75)

Another case similar to this one presented throughout the data collection period. However he was not interviewed as he was too aggressive with the psychiatric registrars and his answers were too inconsistent between registrars.

Mild Intellectual Disability
RP 86 was a 39 year old male. He had a mild intellectual disability and had previously made numerous self harm attempts. He described this attempt as a way of gaining attention because he felt lonely and abandoned by his family and wanted to be admitted to Cumberland so that the staff would take care of him.

Four additional cases had similar presentations. However they were not interviewed because their mental state was too impaired to be able to give informed consent. Three of these cases were younger women who had a mild developmental disability and the last case was an older woman in the early stages of dementia.

Brain damage
RP 67 was a 23 year old male who had sustained mild brain damage in a car accident at the age of 14. He had problems processing information. He had been abusing alcohol and other drugs for a couple of years after the accident. The week prior to his attempt he lost his job and he felt like a failure. He felt that his life had not been worth living since the age of 14. He felt that everybody else was having careers and were going somewhere with their lives and that he lacked this.

A second case very similar to this one presented during the data collection period but was not interviewed due to an inability to gain informed consent.

Psychotic at time of interview
Another important group that was identified in this study was of participants who were psychotic at the time of the interview. Throughout the course of this study 12 people presented in this way. However no data were collected in regards to these cases because of issues of informed consent.
Summarising the groups

Participants who attempt to harm themselves had all experienced feelings of Psychache. However, from this study it emerged that the circumstances surrounding this state are varied. When combining the risk factors as presented in the life histories of the participants with the Psychache described (triggering event, feelings of self harm, and intentions described), it was possible to identify a small number of groups. In this study participants were divided into acute and chronic groups. The acute groups were composed of participants who generally had a good functioning throughout their lives before experiencing a drop in their functioning. The attempt was made whilst they experiencing these difficulties. The participants in the chronic groups described their issues as longstanding.

Four acute groups were identified:

- Psychiatric Condition (depression and schizophrenia). The attempt was associated with a loss of functioning due to psychiatric factors, depression or schizophrenia.

- Social stressors:
  - Impulsive (Overwhelmed): this group was characterised by a loss of functioning due to social stressors. The attempt was characterised by short lived feelings of depression when coping with a large number of stressors.
  - Impulsive (Gain Control) this group was characterised by a loss of functioning due to a perceived loss of control. The attempt was characterised by short lived feelings of depression when dealing with this loss.
  - Non-impulsive (Loss of Self): this group was characterised by a loss of functioning due to a loss of relationship or employment. The attempt was characterised by intense feelings of depression after a significant loss.

The life histories of the participants in the Chronic groups are very different. These participants described difficulties functioning throughout their lives, and their attempt was related to underlying feelings of depression related to general difficulties with functioning. This study identified four main groups in this group.
Drug and/or Alcohol Abuse. This group was characterised by participants having general difficulties coping with life. The actual attempt stemmed from underlying feelings of depression accentuated by the influence of drugs and/or alcohol. The self harm attempt was part of a large number of dysfunctional behaviours such as violent outbursts, drug and alcohol abuse and a criminal history. The group was separated into three subgroups:

- Impulsive
  - Under the Influence
  - Drug induced psychosis
- Non Impulsive (Drug Withdrawal)

Social stressors – Impulsive: this group was subdivided into two.

- Low Self worth: This group was characterised by general difficulties coping with life. The actual attempt appears to stem from feelings of rejection by others, and is part of a large number of dysfunctional behaviours such as violent outbursts, drug and alcohol abuse and a criminal history.
- Self Hatred: This group was characterised by general difficulties coping with life, and the actual attempt is a way of escaping these feelings. The attempt was part of a large number of dysfunctional behaviours such as violent outbursts, drug and alcohol abuse, and a criminal history.

Social Stressors – Non Impulsive:

- Disconnection: this group was characterised by underlying feelings of disconnectedness with the world and feeling overwhelmed by life events.

Five additional groups also emerged four of which were associated with possible cognitive impairment. These included: 1) epilepsy, 2) intellectual disabilities, 3) brain damage and 4) psychosis. An additional case presented as wanting to be admitted as a solution to find accommodation. However as noted previously these five additional groups were not investigated further in this study.

Different risk factors appeared to be associated with each group. The risk factors that were reviewed in combination with the circumstances of the index attempt included: demographic variables, psychiatric diagnoses (Axis 1, Axis 2 and drug and/or alcohol
abuse), childhood experiences, history of general functioning, and previous attempts. A further set of data was concerned with the mental state at the time of the interview. Below are summary tables of the presence or absence of the different risk factors. These tables are intended for summary purposes only. Because of the large number of risk factors involved in each of the cases and the complexity of the interaction between the different risk factors, the different associations of these risk factors within the different groups need further confirmation. The seven tables summarise these trends\(^{32}\). The columns represent the different groups and the rows represent the different risk factors. The figures presented are in percentages and again need to be interpreted with caution as the numbers from which these percentages have been calculated are low. Table 7.1 summarises the demographic characteristics of the different groups, Tables 7.2 and 7.3 summarise the different psychiatric diagnoses within the groups, Table 7.4 reports on adverse childhood experiences present in the different groups, Table 7.5 provides a summary of the general functioning or participants in the different groups, Table 7.6 details the circumstances of index attempt of groups and table 7.7 provides a summary of mental state at the time of the interview for each group. In the tables noteworthy trends are “greyed-in”

\(^{32}\) As the risk factors for the subgroup Drug and Alcohol appear to be similar for summary purposes these two groups are represented in the same column.
Table 7.1: Summary of demographic characteristics of groups

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<th>CHRONIC GROUPS</th>
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140
Table 7.2: Summary of presence of psychiatric diagnoses in groups

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<th>CHRONIC GROUPS</th>
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<td>Gain Control</td>
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<td>Disconnected</td>
<td>Self Hatred</td>
<td>Low Self worth</td>
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<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>12.5</td>
<td>20</td>
<td>10</td>
<td>12.5</td>
<td>20</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>20</td>
<td>/</td>
<td>20&lt;sup&gt;33&lt;/sup&gt;</td>
<td>/</td>
<td>/</td>
<td>5</td>
<td>10</td>
<td>12.5</td>
<td>20</td>
</tr>
<tr>
<td>Other type of depression</td>
<td>/</td>
<td>/</td>
<td>20</td>
<td>/</td>
<td>/</td>
<td>5</td>
<td>/</td>
<td>12.5</td>
<td>6.5</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>/</td>
<td>72</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Drug induced psychosis</td>
<td>/</td>
<td>14</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>13.5</td>
</tr>
<tr>
<td>Bi-polar (manic phase)</td>
<td>/</td>
<td>14</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

<sup>33</sup> Does not add to a 100 because of co-morbidity.
Table 7.3: Summary of presence of personality disorders in groups

<table>
<thead>
<tr>
<th></th>
<th>ACUTE GROUPS</th>
<th>CHRONIC GROUPS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depression (n=5) %</td>
<td>Schizophrenia (n=7) %</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>20 / / / / 50</td>
<td>65 100 75 40</td>
</tr>
<tr>
<td>Borderline</td>
<td>20 / / / 25</td>
<td>60 50 12.5 /</td>
</tr>
<tr>
<td>Anti-social</td>
<td>/ / / / /</td>
<td>/ 30 25 33</td>
</tr>
<tr>
<td>Dependent</td>
<td>/ / / / 25</td>
<td>5 10 37.5 12</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>/ / / / 25</td>
<td>/ 10 / /</td>
</tr>
<tr>
<td>Drug and/or alcohol abuse</td>
<td>20 71.5 20 / /</td>
<td>20 100 100 100</td>
</tr>
</tbody>
</table>
Table 7.4: Summary of childhood experiences of groups\textsuperscript{34}

<table>
<thead>
<tr>
<th></th>
<th>ACUTE GROUPS</th>
<th></th>
<th></th>
<th>CHRONIC GROUPS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depression</td>
<td>Schizophrenia</td>
<td>Overwhelmed</td>
<td>Gain Control</td>
<td>Loss of Self</td>
</tr>
<tr>
<td></td>
<td>(n=4) %</td>
<td>(n=5) %</td>
<td>(n=7) %</td>
<td>(n=3) %</td>
<td>(n=4) %</td>
</tr>
<tr>
<td>History of</td>
<td>/</td>
<td>20 (n=1)</td>
<td>28 (n=1)</td>
<td>/</td>
<td>25 (n=1)</td>
</tr>
<tr>
<td>childhood abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaotic family</td>
<td>/</td>
<td>25 (n=1)</td>
<td>25\textsuperscript{35} (n=2)</td>
<td>/</td>
<td>20\textsuperscript{35} (n=1)</td>
</tr>
<tr>
<td>background</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{34} Only known percentages are reported in this table. The percentages are calculated on the known cases, the numbers below the percentages in the heading row are the number of cases from which the percentage is calculated.

\textsuperscript{35} Calculated on 8 cases

\textsuperscript{36} Calculated on 5 cases

\textsuperscript{37} Calculated on 6 cases
<table>
<thead>
<tr>
<th></th>
<th><strong>ACUTE GROUPS</strong></th>
<th><strong>CHRONIC GROUPS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depression (n=5)</td>
<td>Schizophrenia (n=7)</td>
</tr>
<tr>
<td>Chaotic lifestyle</td>
<td>/</td>
<td>57</td>
</tr>
<tr>
<td>Good functioning</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Drop in functioning</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Anger</td>
<td>20</td>
<td>57</td>
</tr>
<tr>
<td>Violent behaviour</td>
<td>20</td>
<td>57</td>
</tr>
<tr>
<td>Gambling</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Criminal history</td>
<td>/</td>
<td>28</td>
</tr>
<tr>
<td>Feelings of disconnectedness</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>
Table 7.6: Summary of previous attempts and circumstances of index attempt of groups

<table>
<thead>
<tr>
<th></th>
<th>ACUTE GROUPS</th>
<th>CHRONIC GROUPS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous attempts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 to 30 minutes</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>30 minutes to 1 hour</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>1 to 3 hours</td>
<td>/</td>
<td>12.5</td>
</tr>
<tr>
<td>3 to 6 hours</td>
<td>/</td>
<td>15</td>
</tr>
<tr>
<td>&gt; 6 hours</td>
<td>60</td>
<td>5</td>
</tr>
<tr>
<td><strong>Presence of social stressors</strong></td>
<td>40</td>
<td>70</td>
</tr>
<tr>
<td><strong>Relationship breakdown</strong></td>
<td>/</td>
<td>45</td>
</tr>
<tr>
<td><strong>Under influence of alcohol</strong></td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>
Table 7.7: Summary of mental state at the time of the interview of groups

<table>
<thead>
<tr>
<th></th>
<th>ACUTE GROUPS</th>
<th></th>
<th>CHRONIC GROUPS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depression</td>
<td>Schizophrenia</td>
<td>Gain Control</td>
<td>Loss of Self</td>
</tr>
<tr>
<td></td>
<td>(n=5) %</td>
<td>(n=7) %</td>
<td>(n=3) %</td>
<td>(n=8) %</td>
</tr>
<tr>
<td>Same feelings at</td>
<td>80</td>
<td>/</td>
<td>/</td>
<td>62.5 %</td>
</tr>
<tr>
<td>time of interview</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same (with shift</td>
<td>20</td>
<td>100</td>
<td>/</td>
<td>25 %</td>
</tr>
<tr>
<td>away from impulse)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shift of mindset at</td>
<td>/</td>
<td>/</td>
<td>100</td>
<td>12.5 %</td>
</tr>
<tr>
<td>time of interview</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted to</td>
<td>80</td>
<td>72</td>
<td>/</td>
<td>62.5 %</td>
</tr>
<tr>
<td>psychiatric unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Prior to describing these trends it is again important to note that the numbers in the groups are relatively small and care needs to be taken when interpreting the results. Keeping this in mind the section below will describe the observed trends within the groups.

**Demographic trends**
From table 7.1, it can be noted that in this sample some trends have emerged regarding the ages of the participants. Participants in this study in the groups Depression and Drug and/or Alcohol Abuse were older. Eighty percent of the participants in the group Depression and 73.5% in the group Drug and/or Alcohol were over the age of 35. In contrast, 100% of the participants in the group Schizophrenia, 95% of those in the group Disconnection and 62.5% of those in the group Low Self Worth were under the age of 35. No specific age trends emerged in this study in relation to the other groups. The gender distribution needs to be interpreted with additional caution as there is an overrepresentation of females in this sample. However of note is that the majority of the participants in the group Low Self Worth (62.5%) and Drug and/or Alcohol Abuse (80%) were males; whereas all participants (100%) in the group Disconnection were female.

**Psychiatric diagnoses**
Tables 7.2, 7.3 and 7.4 report on the distribution of mental illness, personality disorders and drug and/or alcohol abuse. Definite trends appeared to have emerged. Not surprisingly the more severe and disabling mental illnesses were mainly found within the groups Depression and Schizophrenia. Eighty percent of the participants in the group Depression were diagnosed with a major depression and bi-polar disorder. All participants in the group Schizophrenia were diagnosed with a psychotic disorder. No real trend emerged with the diagnosis of adjustment disorder or depression not otherwise specified, which was likely to occur within the other six groups. Table 7.3 reported on the distribution of personality disorders and drug and/or alcohol abuse according to the different groups, and shows that these are more likely to occur within the chronic groups Disconnection (60%), Self Hatred (100%) and Low Self Worth (85%). The diagnosis of drug and/or alcohol abuse was more likely to occur within the groups Schizophrenia (71.5%), Self Hatred (100%), Low Self Worth (100%) and Drug and/or Alcohol Abuse (100%).
Childhood experiences

Table 7.4 reports on the adverse childhood experiences of participants. It can be noted that participants in the groups Self Hatred, Low Self Worth and Drug and/or Alcohol Abuse are likely to have reported a history of childhood abuse and to have described their family of origin as chaotic. All the participants in the groups Self Hatred described a history of childhood abuse (100%). Eighty percent of the participants in the group Low Self Worth and 72.7% of the participants in the group Drug and/or Alcohol Abuse described a history of childhood abuse. All participants in the groups Self Hatred and Low Self Worth (100%) and 90.9% of the participants in the group Drug and/or Alcohol Abuse described their family of origin as chaotic.

Summary general functioning

Table 7.5 summarised the general functioning of participants in this study. Marked differences are present in relation to these characteristics between the groups that were described as acute and chronic. Participants in the groups Self Hatred, Low Self Worth and Drug and/or Alcohol Abuse, all (100%) described their lifestyle as chaotic and reported difficulties functioning in different areas. All participants in the group Self Hatred reported having difficulties managing their anger, and described violent behaviour; 80% of the participants in this group also reported difficulties with gambling and 80% reported a criminal history. Similar trends were present for the participants in the groups Low Self Worth and Drug and/or Alcohol Abuse. Seventy five percent of the participants in the group Low Self Worth and 87% in the group Drug and/or Alcohol Abuse reported difficulties managing their anger. Eighty seven percent of the participants in the group Low Self Worth and 74% of the participants in the group Drug and/or Alcohol Abuse reported difficulties with violence. Both groups were also likely to reported a history of gambling and a criminal history. None of the participants in the chronic groups described a drop in their functioning.

With the exception of the group Schizophrenia, none of the participants in the acute groups reported a history of gambling and/or a criminal history. A little more than half (57%) of the participants in group Schizophrenia were also likely to describe a chaotic lifestyle, difficulties managing anger and violent behaviour. Those who had reported a drop in their functioning were all classified in the acute groups.

38 Due to the large number of unknowns the variable “parents defined as emotionally distant” was not included in Table 7.4.
39 The percentages are calculated on known cases only.
Previous attempts and circumstances of the index attempt
Table 7.6 reports on previous attempts and the circumstances of the index attempt. Participants in all groups (with the exception of the Gain Control group) were likely to have made a previous attempt. The proportion of participants with previous attempts in the chronic groups Self Hatred, Low Self Worth and Drug and/or Alcohol Abuse was very high (100%, 75% and 93.5% respectively). Similarly a high percent of those in the acute group Schizophrenia (86%) had also made a previous attempt.

Trends also appear around the duration of the self harming thoughts. Participants in both the acute and chronic groups had made impulsive attempts. Participants in the acute groups Schizophrenia, Overwhelmed and Gain Control, and those in the chronic group Self Hatred, Low Self Worth and Drug and/or Alcohol Abuse were more likely to have thought about the attempt between five and 30 minutes. The attempt was more deliberate for those in the acute groups Depression and Loss of Self. No obvious pattern emerged for those in the acute groups Depression and Loss of Self. No obvious pattern emerged in the group Disconnection.

State of mind at the time of interview
Table 7.7 summarises the mental state of the participants at the time of the interview. Interesting differences emerged between the different groups. No real differences were apparent between the acute and chronic groups, however within each groups it can be seen that participants within the acute groups Depression, Schizophrenia and Loss of Self, and those in the chronic group Disconnection were likely to feel the same at the time of the interview as at the time of the attempt. Some of the participants described a shift away from the actual impulse to harm themselves but still described similar feelings as those that caused the Psychache at the time of the event. A marked shift in the mindset was noted for the participants in the acute groups Overwhelmed and Gain Control and the chronic groups Low Self Worth and Drug and/or Alcohol Abuse. All participants in the groups Overwhelmed, Gain Control and Low Self Worth described a marked shift in their mindset, and 60% of the participants in the group Drug and/or Alcohol Abuse reported this shift. There was no real trend that was noted within the group Self Hatred. This finding may shed some light on some of the strategies that can be developed to deal with suicidal behaviour and will be discussed in Chapter 9.

Conclusions
In this study different groups were identified, each of which appeared to have a specific set of characteristics. These have been described in detail in the current and previous chapter. Ten subgroups have been identified in this study, and the
association of risk factors with these groups will require further investigation. The implications of these findings will be discussed in the next chapter.
Chapter 8: Discussion

This study focused on accounts of the circumstances leading up to a deliberate self-harm attempt. In this study the life histories of 90 participants who had come to the attention of the Accident and Emergency Department of Westmead Hospital after a deliberate self-harm attempt were analysed. The overall aim was to gain an in-depth understanding of deliberate self-harm, taking into account risk factors and stated motives for attempt. This was achieved by:

1. Investigating the presence of risk factors known to be associated with deliberate self-harming behaviour;
2. Establishing the stated motives for deliberate self-harming behaviour of people who have come to the attention of the Accident and Emergency Department of Westmead Hospital after an attempt to harm themselves; and
3. Investigating the relationship between risk factors and the reason(s) people gave for self harm.

This chapter revisits the main findings of this study and discusses these with respect to the study aims and the literature on suicidal behaviour. It also draws attention to implications for strategies aimed at prevention of deliberate self-harming behaviour.

Aim 1: Risk factors identified

A quantitative analysis exploring the presence of known risk factors in the current sample was undertaken and the findings reported in chapter 4. Some of the sample characteristics noted in the current study mirror those of other studies into deliberate self-harm. Below the main findings are briefly revisited and discussed in relation to the research available on deliberate self-harm.

Demographic characteristics

The majority of the participants in the current study were female, single or experiencing a relationship breakdown and unlikely to be in the workforce at the time of the attempt. As described in Chapter 2 these trends are very similar to findings reported in the literature on deliberate self-harm (for example Hassan, 1996). In addition the majority of the participants in the study sample had taken an overdose. Again this is consistent with previous research where drug overdoses remain the most common method of deliberate self-harm for both men and women who present to the emergency department (Steenkamp and Harrison, 2000). The relative large proportion of participants who present to the emergency department after an overdose (compared to other methods of self-harm) could be attributed to the fact
that an overdose does require medical attention; whereas if a person chooses other methods (such as hanging, drowning or cutting) and survives their attempt, he or she often does not require any medical attention as the only physical consequences of their attempt are often minor injuries such as bruising around the neck. These people are more likely to present to their General Practitioners. (Jacobs et al, 2003).

**Characteristics of the attempt**

The majority of the participants in the current study described the deliberate self-harm attempt as impulsive. The impulsive nature of deliberate self-harm attempt found in the sample is reflective of findings by Williams (1986, 1997), who noted that between 50% and 70% of people who had tried to harm themselves had thought about the attempt for less than one hour. Simon and colleagues (Simon et al, 2001) also found that 24% had spent less than five minutes thinking about the attempt.

In the study sample, one third of the participants had their judgement impaired by alcohol and the majority of those under the influence of alcohol (65%) were males. The presence of alcohol in a deliberate self-harm attempt has been previously documented (Murphy, 2000). In the current study there was a strong association between those who attempted under the influence of alcohol and those who had made an impulsive attempt. 93% of those who were under the influence of alcohol thought about their attempt for less than 10 minutes compared to 55% of those who were not under the influence. Suominen and colleagues (1997) noted a similar result. In their study people who had made a deliberate self harm attempt and were diagnosed with alcohol dependency appeared to be more impulsive. These findings suggest that substance abuse, in particular alcohol abuse, can play a significant part in a person’s decision to harm themselves.

In the current study marked differences were observed in the respondents’ state of mind described at the time of the interview from their reported state of mind at the time of the deliberate self-harm event. The impulse to harm themselves had disappeared for four fifths of the respondents (79%). For almost half of this group (46%) there was a marked shift in their mental state, as they were either able to problem-solve about the situation they described as causing them pain or were calm about the issues they had experienced leading up to the attempt. One third (33%) of the people in this sample still described feelings similar to those experienced at the time of the attempt but the impulse to harm themselves had disappeared. Alcohol appeared to be one of the contributing factors in the variation of the time of the impulse to harm themselves; a little less than half (46%) of the sample who
attempted under the influence of alcohol described a shift in the mindset at the time of the interview.

The change of mental state at the time of the interview, combined with the impulsive nature of the attempt, suggests that for many the suicidal/deliberate self harming state is only temporary and short lived.

**Previous attempts**

Two thirds (70%) of the sample had made a previous deliberate self harm attempt. Again this trend has been documented (for example Beautrais, 1998)). Of note in the current study is that 71% of those who have attempted in the past had made their previous attempt within the six months prior to the index attempt. Only 14% of those who had attempted in the past had done so more than one year prior to their index attempt. In addition the vast majority of the participants described the circumstances of their previous deliberate self harm attempts as similar to one they were presented with at the time of the index attempt, which suggest that deliberate self harming is used as a coping strategy under similar circumstances.

**Psychiatric diagnoses**

Mental illness, was evident in this study. Eighty five percent of the sample was diagnosed with a mental illness by the treating psychiatrists. Mental illness is a well established risk factor for self harming behaviour with research suggesting between 70- 90% of people who had attempted suicide having a diagnosable mental illness. The diagnoses given were mainly depression (73%) and psychotic disorders (11%)⁴⁰. These trends are consistent with those noted in the literature where the most common diagnoses are depression (up to 90%) and schizophrenia (up to 10%) (Beautrais, 1996; Davison, 2001).

A variety of types of depression have been identified in this study, these included adjustment disorder, depression not otherwise specified and major depression. Although these disorders are part of the same spectrum and the feelings and emotions associated with them are similar, the aetiologies are diverse. These mood disorders have similar features including feelings of sadness, loss of interest in nearly all activities, feelings of worthlessness and guilt; however, they distinguish themselves through the onset of the symptoms and the severity and impact of these symptoms on a person’s general functioning (American Psychiatric Association, 2000). The differences between the different psychiatric disorders and the impact of

⁴⁰The percentages in this study will need to be interpreted with caution because people who were too psychotic at the time of the interview were excluded from the study.
these on the deliberate self harm attempt will be discussed in more detail later in this chapter.

Drug and alcohol abuse also emerged as a risk factor in this study, with 53% of the sample fulfilling the criteria for Drug and/or alcohol abuse. Drug and alcohol abuse has been identified as being a major contributing factor to suicidal behaviours (Haw et al, 1997; Murphy, 2000)

Personality disorders, in particular borderline and anti-social, are also highly represented in this sample. Forty seven percent of participants were diagnosed with a personality disorder by the treating psychiatrist(s). As described in chapter 2, personality disorders have also consistently been linked to suicidal behaviour (Linehan, Rizvi, Welch and Page, 2000). In this study the main personality disorders associated with deliberate self harming were borderline and anti-social personality disorders. Both these personality disorders belong to the cluster B personality disorders, and are characterised by a pattern of impulsivity which manifests as a failure to plan ahead (American Psychiatric Association, 2000). It is not surprising that these two personality disorders appear to be associated with deliberate self harming behaviour, considering the impulsive component of these disorders and the impulsive nature of a deliberate self harm attempt.

**Social stressors**
The impact of social stressors, in particular relationship breakdowns, was also evident in this sample. The vast majority of the participants in the current study (83%) had more than one stressor in their lives prior to the attempt. The presence of social stressors, in particular interpersonal conflicts, prior to a deliberate self harm attempt has been previously documented (for example Beautrais, 1998). The impact of these stressors on the attempt will be discussed in more detail later in this chapter.

**Behavioural background**
Forty percent of the participants described violent and aggressive behaviours and 62% of these were males. These behavioural characteristics have also been described in the literature. For example Catrogiovanni and colleagues (1998) noted that aggressive behaviour is considered to be an important risk factor for suicidal behaviour. Brent and colleagues (1993) noted that males tend to have higher degrees of lifetime aggression and an increased tendency to impulsive violence, assaulitive behaviour, and homicidal ideation in the week prior to an attempt. The link between deliberate self harming behaviour and violence/aggressive behaviour is not surprising as they have been viewed as shared features of underlying problems.
Nock and Marzuk (2000) conceptualised suicidal behaviour and violence as “overlapping end points on a continuum of aggressive behaviour” (p. 451).

**Family characteristics**

Family characteristics such as adverse childhood experiences and childhood abuse emerged as significant factors in this study. These factors have also been found in previous literature on deliberate self harm. Young people and adults who engage in deliberate self harming behaviour are more likely to have experienced family violence and abuse, changes in the social environment such as relationship breakdown or conflict with their family of origin (for example Silburn et al, 1991, Beautrais, 1998). The relationship between childhood abuse and subsequent maladaptive behaviour has been hypothesised to be indirect. The moderator variables may interact with each other or with consequences of physical abuse in their effects on behaviour. These variables can occur concurrently as well as sequentially. For example a coexisting diagnosis of substance abuse may exacerbate violence, suicidality and emotional problems found in physically abused adults (Yang and Clum, 2000).

**Summary**

Overall the findings of this study are in agreement with previous research and highlight that there is no single cause of deliberate self harm and that the causes and risk factors for this behaviour are highly complex.

Different trends and risk factors have been identified within this study, but at the same time the sample described is also characterised by the diversity of backgrounds and experiences. In particular there was a distinction (very clear for most cases) between those people who described the pain or problem situation in which they made the attempt as acute or of short-term nature (37% of the sample) and those who described the circumstances or situations surrounding the event as longstanding or chronic (63% of the sample). This distinction between those who described their pain as acute and those who described their pain as more chronic lay the foundations for a framework by which the various findings from the qualitative and quantitative data collection could be understood. This framework is discussed in the next section.

**Chronic and acute groups**

A distinction was noted between groups of participants, based on the general functioning of the participants throughout their lives and the duration of the problems they described. Their experiences could be classified into two distinct groups namely:
Acute and Chronic. Within the acute group the difficulties coping with the problems had been present for a relatively short period of time, whereas participants in the chronic group described enduring problems which have present throughout most of their lives. The presence of different risk factors within these two groups were explored and described in detail in Chapter 2 and will be briefly revisited at this point.

In the acute group, participants reported a reasonable functioning throughout their lives and described a pivotal event(s), after which they experienced a marked drop in their functioning. It is at this point that an attempt was made. This group is mainly characterised by the presence of an Axis 1 diagnosis (97%). No Axis 2 was diagnosed for 85% of this group and no harmful drug use for 76% of this group. The large majority of this group described their lives as being stable (88%), did not describe any problems with violent behaviour (88%), anger (94%), gambling (97%) or criminal history (94%). Participants described their childhood experiences as stable (83%), and denied any abusive experiences (82%). Forty six percent of this group identified a parental psychiatric history (mainly depression).

Participants who belonged to the chronic group described a multitude of difficulties. The difficulties included maintaining meaningful relationships and employment, drug and alcohol abuse, violent and impulsive behaviour and multiple deliberate self harm attempts. Sixty-three percent of this group described their family backgrounds as being chaotic and 73% percent described a parental psychiatric history (mainly drug and alcohol abuse - 64%). All of the people in this group reported difficulties functioning and 90% described their lifestyle as chaotic. Fifty four percent of the sample described their behaviour as violent, 60% reported difficulties with anger, 45% described gambling difficulties and 35% stated that they had a criminal history. Seventy seven percent of this group were diagnosed with an Axis 1 diagnosis and 63% had a personality disorder. Seventy percent of this sample described harmful drug use.

The characteristics of the chronic group have been described within the literature on deliberate self harm and drug and alcohol abuse. Hawton and colleagues (1997) found that patients who abused drug and/or alcohol and had made an attempt to harm themselves were more likely to be: male; report a history of childhood abuse; unemployed; have made previous attempts; experiencing social stressors (mainly problems with a relationship, housing and legal problems); and consumed alcohol at the time of the event. Other risk factors such as problems in relationship with a partner were also more prevalent in this group.
Aim 2: Stated motives for deliberate self harming behaviour

The second aim of this study was to analyse the stated motives for deliberate self harming behaviour of people who have come to the attention of the Accident and Emergency Department of Westmead Hospital after an attempt to harm themselves. A qualitative analysis was undertaken and reported on in Chapter 5. This analysis was undertaken in two stages.

Stage 1
In the first stage five main motives were identified, namely: 1) A way of coping with situation/social stressors; 2) A response to rejection, wanting to communicate feelings; 3) A way of coping with mental pain; 4) under the influence of mental illness; and 5) Under the influence of alcohol/other drugs. These motives are very similar to those described in the literature. Some of the motives that have been previously been identified include, in no particular order: 1) wanting to die; 2) wanting to escape an impossible situation; 3) to seek help from someone; 4) to get relief from a terrible state of mind; 4) to try to influence some particular person or get them to change their mind; 5) wanting to make people understand how desperate they were feeling; 6) wanting to make things easier for others; 7); and wanting to show how much they loved somebody (Bancroft et al, 1976; Williams, 1986; Williams, 1997).

The classification undertaken in this study, focussing on the main expressed motives was not without difficulties. These were described in detail in chapter 5. It was noted that even though a main theme could be identified, for the majority of the participants the expressed motives at the time of the interview were complex, fluctuating and could contain a mixture of motives. In most cases the motive (even when this was expressed as a wish to die) was also a desire to live without the pain/problem/mental illness. Death or sleep was seen to be preferable to continuing to deal with their pain. This was at times expressed as wanting to die, to have time out or to show others their hurt. For most participants there appeared to be a paradox in that the attempt/death was conceptualised as the death of their problems which is distinct from the death of self. From this analysis it was apparent that people who attempt to harm themselves do so when they are experiencing a great amount of pain and the deliberate self harm attempt is made as a response to this pain. It was noted that regrouping participants based on motive alone raised a number of theoretical difficulties and a further analysis was undertaken.
Stage 2
A further analysis around the motives was undertaken incorporating:

1) the types of problems/situations described and triggering events;
2) whether these problems were chronic (longstanding) or acute (pivotal);
3) persistence of thoughts of self-harm (impulsive or non impulsive/deliberate); and
4) the presence or absence of these feelings at the time of the interview (the resolution of the attempt).

Ten subgroups were identified namely: Acute: psychiatric condition (Non Impulsive - depression and Impulsive - schizophrenia). Acute: social stress (Impulsive – overwhelmed and gain control; Non Impulsive - loss of self); Chronic: Longstanding Drug and Alcohol Issues [Impulsive – Under Influence (alcohol and drug induced psychosis); non impulsive (Drug Withdrawal)]; Chronic: Social Stress (Impulsive – low self worth and self hatred; Non Impulsive - disconnection). These groups highlight the different mental states and situations participants are attempting to escape. Four additional groups may also have emerged from the data collected in this study; However the limited numbers prevented the description of these groups with confidence. These groups included: epileptic fit; mild intellectual disability or mild brain damage; psychosis at the time of the event; and wanting to be taken care off. The characteristics of these groups will be discussed in more detail in the following section.

Aim 3: To investigate the relationship between various risk factors and the reasons people give for self harm

The third aim of this study was to investigate the relationship between various risk factors and the reasons people gave for self harm. The risk factors previously identified in this study, were crosstabulated with the ten subgroups identified in Stage 2, described above. The details of these groups were described in chapters 6 and 741. The following discussion will focus on some of the differences between these groups and, where possible, connections will be made with the existing literature.

41 Appendix 4 provides a brief summary of the dominant characteristics and risk factors associated with each of these groups:
Impact of mental illness:
Depression

As noted earlier psychiatric conditions (in particular the diagnosis of depression) were present in all but one of the groups identified in the current research. There were however differences in the ways participants described the depression and the part it played in their decision to self-harm. For example in the acute group depression the attempt was made whilst in an acute phase of depression and described in terms of wanting to escape the pain associated with the mental illness. It was often expressed as a wish to die and death was conceptualised as a way to stop their depression. Social stressors were present at the time of the event; however, none of the participants in this group attributed the actual attempt to the social stressors and these appeared to be secondary to the mental illness people experienced. Participants in this group stated that they had only ever made a deliberate self harm attempt when they were experiencing an episode of depression.

On the other hand in the chronic loss of self group the feelings of depression were described as being associated with a significant loss. The participants in this group ascribed their attempt to a loss of interest in life after a significant loss their depression was described in direct relation to a loss they could not bear.

Further presentations of depression can be found in the chronic social stressor self hatred and disconnection groups. People in the group chronic self hatred described their underlying feelings of depression being activated by the slightest social stressor. The attempt was described as a way of gaining control over emotions or time out from their feelings. The attempt in this group appears to be linked with their inability to regulate emotions.

The group described as Chronic - disconnection describe yet another way in which the depression was described. Depressed feelings were described in terms of their feelings of disconnectedness with the world. The deliberate self harm attempt was a reaction to minor social stressor(s) and described as a way to have time out from their feelings. For the participants in this group there appears to be a complex interaction between the underlying feelings of depression, their emotional reaction to a social stressor and the impact this has on their emotional state/depressed feelings. It appears that there is a continual feedback loop that occurs between their underlying vulnerability/feelings of depression, which can be activated by a social stressor which, in turn, influences the feelings of depression and this, in turn,

42 Some of the personality factors that are appear to be associated with this group will be discussed later in this chapter.
influences their emotional state. The participants in this group had made multiple attempts throughout their lives and appeared to be younger.

The emotional dysregulation described by the participants in the groups *Chronic self hatred* and *Chronic disconnection* has been described in the literature as a very high sensitivity to emotional stimuli, a very intense response to emotional stimuli, and a slow return to emotional baseline once emotional arousal has occurred (Linehan, 1993). For participants in the chronic groups social stressors the deliberate self harm attempt appeared to facilitate this return to baseline.

The differences in the experience of depression observed in this study have been described within the literature. Soloff and colleagues (2000) compared participants with major depression who had made an attempt to harm themselves to those with major depression and an associated personality disorder (without drug and alcohol abuse). Patients with borderline personality disorder did not differ from patients with major depression in self-reported depression but they had significant lower scores from observed depression; however the group with personality disorders had a high degree of subjective distress. Patients diagnosed with borderline personality disorder were mainly younger and had made multiple suicide attempts (Soloff et al, 2000). In addition patients diagnosed with a major depression who had attempted to harm themselves were characterised by high levels of intent and high levels of hopelessness (Suominen, 1997). Adolescents who were diagnosed with major depressions were more likely to express a wish to die (Groholt et al, 2000). Patients diagnosed with major depression who had made an attempt to harm themselves were also less likely to experience interpersonal loss and conflict (Rich et al, 1988; Suominen et al, 1997). When patients diagnosed with a major depression were compared to patients who had an associated borderline personality disorder, patients who had a major depression alone were significantly older (Soloff et al, 2000).

The participants in the current study described depressions which differed in terms of onset and duration as well as in terms of the pain with which the depression was associated. The depressions described included an acute episode in an otherwise managed mental illness; an underlying depression triggered by social stressors; a depression triggered by a significant loss; and, a depression described in terms of an underlying feeling of disconnection. Depression is clearly a very significant factor in the decision to engage in serious self-harm, and its presentation can be complex. Understanding the types of depression experienced may lead to different clinical judgements and may provide guidance in the development of strategies to deal with people who have made a deliberate self harm attempt.
Schizophrenia

The characteristics of the acute Psychiatric (Schizophrenia) group were distinct from the other groups. Participants in this group described their actual attempt as impulsive and wanting to escape the pressing nature of their symptoms. They felt overwhelmed or confused by the symptoms of their illness and the attempt was made to stop the confusion associated with these symptoms. In this sample the participants in this group were mainly young adults.

Similar characteristics of those identified in this study have been previously described. Radomsky (1999) found that participants who are diagnosed with schizophrenia or psychotic disorders were characterised by social withdrawal, social skills deficits and lack of social contact. Heila and colleagues (1999) noted that the life events appear to be less prominent before a suicide among victims with schizophrenia compared to those without schizophrenia, and the actual attempt was more likely to occur in the active phase of the illness and was ascribed to internal illness related factors (Heila et al, 1999). Radomsky (1999) also noted that it is during the early stages of the illness that participants who have schizophrenia often attempt suicide.

Social stressors

Social stressors were present in the majority of the identified groups. However, as with the risk factor depression, the participants described the influence of these stressors on their attempt in different ways even if, on the surface, the attempt appears to be similar. Some of these differences have already been briefly mentioned in the discussion above.

Participants in the acute gain control group and in the chronic low self worth group described their self-harming action as a reaction to a fight with a significant other. All described feelings of rejection by others and their attempt was described as trying to escape and/or communicate these feelings. However differences were noted in the process behind the attempt. The acute gain control group attributed their attempts to wanting to gain control over the situation. Whereas the chronic low self worth group described longstanding feelings of lack of self-worth, which resurfaced after a loss of a relationship.

The characteristics associated with these two groups have been described within the literature. For example Simon and colleagues (2001) found that an impulsive suicide attempt appears to be immediately preceded by interpersonal conflicts. The authors suggested that these impulsive suicide attempts might be a response to these
conflicts rather than an actual desire to die. Impulsive attempts were more likely for subjects that scored relatively low on depression and were involved in physical fights (Simon et al, 2001).

Differences of the impact of social stressors on the attempt were also observed between the acute overwhelmed group and the chronic self hatred group. All the participants described their attempt as a reaction to a particular set of social stressors; however, while the participants in the acute overwhelmed group specifically identified the social stressors as causing a decline in functioning, the participants in the chronic self hatred group described the issues that overwhelmed them as a confirmation that their lives were not worth living and described having a number of other known risk factors for self-harming behaviour. The participants in the group overwhelmed group described the attempt as a response to a specific set of circumstances.

The emotional dysregulation associated with the chronic self hatred group has already been explored above in the section discussing the impact of depression. Different types of processes appeared to be associated with the acute groups. These will be briefly explored below.

Cummins and Lau (2002) theorised that it is not the actual stressor that causes maladjustment but the person's perception of this stressor. Personality appears to play an important part in determining the perceived impact of different stressors on a person’s well-being. Locus of control has been hypothesised as being one of the factors associated with this process. A person has both internal and external locus of control. External locus of control attributes such control to external agencies such as luck or some powerful other person or force. Internal locus of control is present in those people whose perception of control over an event rests within themselves (Hjelle and Ziegler, 1992). Under normal conditions, internal locus of control acts as a protective factor. However some external locus of control is needed in times of stress in order to act as a buffer against the potential negative impact of these stressors, which means if a person has a strong internal locus of control and a very weak or non existent external locus of control, the homeostasis is threatened when a large amount of social stressors occur (Cummins et al, 2002).

Locus of control was not specifically investigated in this study. However participants in the Overwhelmed and Gain Control groups described a sense of generally feeling in control of their lives. This could be interpreted as a sign of strong internal locus of control.

43 The authors described any type of maladjustment. A deliberate self harm attempt is one of these.
control (Hjelle and Ziegler, 1992). It is possible that participants in the acute groups Overwhelmed and Gain Control felt that the stressors had diminished their competence, and experienced this as a loss of control over the situation. A strong internal locus of control had acted as a protective factor throughout most of their lives; however the stressors present at the time of the event for the participants in these two groups may have acted as a ‘tipping point’, pushing their subjective sense of well being out of the range of their optimal level. Therefore the subjective emotional state was threatened (Cummins et al, 2002). The type of locus of control was not specifically investigated in this study and this hypothesis will need testing for these specific groups.

In the acute loss of self group, the opposite process could play an important part in the suicidal process. Again locus of control was not specifically investigated in this study; however, participants in the acute loss of self group described a loss of self after the loss of relationship/employment, and this could be interpreted as an indication that this group has a high external and low internal locus of control as they described their sense of self being associated with the external object. The presence of social stressors prior to an attempt has been consistently described in the literature on deliberate self harm (De Leo et al, 1999; Beautrais, 1998). It has also been suggested that personality factors and locus of control can play a role in the suicidal process (Beautrais et al, 1999).

Evidence for existence of additional groups

Four cases in the current study were classified separately. Some of the characteristics associated with these groups will be briefly explored. There is some evidence for the existence of three as separate groups within the literature.

Epileptic fits following longstanding drug and alcohol abuse.

As described in Chapter 7, two participants presented with epileptic fits after a lifetime of drug and alcohol abuse. There is some suggestion within previous research that there is an association between longstanding drug and alcohol abuse, the development of epileptic fits and suicidal behaviour. Barraclough and colleagues found that epilepsy is associated with a high suicide rate. These two cases can present a possible group leading to deliberate self harming behaviour. However the impact of the epilepsy on the attempt remains an area for further investigation.

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44 This is demonstrated by the fact that for the participants in these two groups the index attempt occurred at a later stage in their lives and most of the participants in these groups had not made a previous attempt.

45 One of these cases was not interviewed because of issues concerning informed consent.
Mild intellectual disability

A total of five cases who presented to the hospital after an attempt to harm themselves had a mild intellectual disability. There is some evidence in the literature that intellectual disability might be a risk factor for suicidal behaviour. Different studies have noted that even though it is a relatively rare event, suicide among participants with intellectual disabilities occurs (Hardan and Sahl, 1999; Walters et al, 1995). There is little information available on this group and more research is needed even though this is difficult because of issues surrounding informed consent.

Mild brain damage

During the data collection period two people presented with mild brain damage to the hospital after an attempt to harm themselves. Mild brain damage has been linked to suicidal behaviour in previous research (Simpson and Tate, 2002). Again very little is known about the characteristics of this group and further research is needed.

Wanting to be admitted

One additional case presented as wanting to be admitted. This case was analysed separately. However the associated risk factors are very similar to the group Self Hatred and it is possible that this person represents a variation of this group. Further cases are needed to confirm this trend.

Conclusions

The groups described in this study allowed for a refinement of Shneidman’s (1993) notion of Psychache and has highlighted the differences within the Psychache experienced by the research participants. In addition the way in which similar risk factors can impact on a deliberate self harm attempt has been discussed.

This study has extended Beautrais (2000) model of deliberate self harm presented in Chapter 1. Firstly it divided the life histories leading up to the attempt into chronic and acute; secondly it added a further two dimensions namely 1) whether or not the attempt was made on impulse; and 2) the impact of the attempt on the mental state of people who attempted to harm themselves. Lastly it highlighted the differences within the Psychache described at the time of the attempt. Figure 8.1 presents the revised model.

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46 Because of issues concerning informed consent only one of these was interviewed
47 Because of issues of informed consent only one of these was interviewed
For each of the groups identified within this study the different risk factors appear to interact with and impact on the deliberate self harm attempt in different ways. The groups presented in this thesis, to the best of the authors knowledge, have not been identified in this manner within the literature. The groupings of risk factors within each group will need further confirmation.

**Difficulties with this approach**

**Difficulties with classification into chronic and acute**

The classification introduced between chronic and acute was not without difficulty. As was discussed in Chapter 4, a particularly difficult group to classify were those diagnosed with major psychiatric illnesses and who described their attempt as wanting to escape the symptoms associated with their illness. This group identified an interruption to good functioning caused by their mental illness. For some the illness was episodic whereas for others (in particular for those who were diagnosed with schizophrenia) the impact of the illness on their functioning was severe and caused great pain and impairment to their functioning. In this case the consequences of their illness on their functioning were longstanding. In this study those diagnosed with a mental illness were classified as acute as there was a definite change in their functioning at the onset of their illness. This classification is consistent with the differentiation between Axis 1 and Axis 2 diagnoses. However in a study that
reviewed deaths by suicide and risk taking of young people aged 12 to 17, people who described having a psychiatric illness were classified as having “enduring problems” (Sankey and Lawrence, 2003). The issue as to where this group belongs, whether and not a distinction needs to be introduced between episodic and chronic illnesses, or whether or not this group constitutes a separate group needs further investigation. The sample size in this study was too small to draw these distinctions. This is an issue that needs investigation.

**Difficulties with subdivision into different groups**

The proposed groups of deliberate self harming behaviour are also not without difficulties. Firstly the different groups are classified around the motives described after a deliberate self harm attempt, which implies that in order for people to be classified into these groups they will have to have made a deliberate self harm attempt. It is however possible as further research is undertaken that specific risk factors and characteristics will be identified that allow for the identification of the groups prior to the attempt.

Secondly the groups identified in this study are not homogeneous and there is a considerable overlap of identified risk factors between the different identified groups. There appear to be associations between different risk factors and particular groups, however from this study no definite conclusions could be made regarding to this and further research is required to determine the association between specific risk factors and different groups and their impact on the decision to self harm.

Thirdly the main groups that have been identified within this study are not exhaustive, as the three additional cases have shown that other groups can lead to self harming behaviour. Additional groups are likely to emerge from future research. These groups can come from subdivisions of the current groups or emerge from additional cases. There is a risk that if too many groups and sub-groups are found, we may descend into total confusion in our understanding of suicide, and not be able to differentiate any patterns.

Lastly the different identified groups show a link with suicidal behaviour but do not necessarily explain why these participants facing the problems they describe respond with a deliberate self harm attempt rather than any other response. The different groups distinguish themselves from each other and the internal logic of the attempt appears to be clear. However what remains unknown is why people, who have similar characteristics to those who participated in this study, do not attempt to harm themselves. Research into the differences of coping between those who attempt to
harm themselves and those who do not is needed in order to understand the interrelationship between certain risk and protective factors and deliberate self harming behaviour.

Not withstanding these concerns one of the major strengths of the proposed model lies in the fact that it encompasses individual, social, psychiatric as well as psychological factors as well as teasing out the qualitative differences between the groups. It was noted in Chapter 2 that deliberate self harm is a multi-dimensional act and the group approach reflects this multidimensionality. There is a need for the confirmation and consolidation of the different groups identified, and it is possible that different groups will emerge in future research. However the groups identified in this research and the framework proposed to understanding deliberate self harming behaviour remains useful. It provides the beginnings of a theoretical understanding of the logic behind a deliberate self harm attempt.

**Implications for prevention**

In this study a diversity of risk factors, experiences and mental states have been described. It was noted that for different individuals these factors impact on the decision to self harm in a variety of ways. The issues associated with the acute group appear to be very different to those associated with the chronic group and prevention strategies will need to take these into account. In addition similar risk factors appear to influence the deliberate self harm attempt in different ways. The diversity of experiences of people who attempt to harm themselves highlights the importance of diversifying the prevention strategies. This need for a range of approaches has also been noted within the national suicide prevention strategy of Australia. The document ‘A framework for prevention of suicide and self harm in Australia, Areas for action’ (Commonwealth Department of Health and Aged Care, 2000b) noted the importance for prevention strategies to acknowledge the need for a range of approaches, targeting the whole population, specific population subgroups and individuals at risk. Below some strategies for the prevention of suicidal behaviour will be discussed. The strategies/therapeutic interventions and areas for research described below are not intended to be an exhaustive list.

**Strategies targeting individual risk factors**

**Depression**

This (and other) study(s) highlighted the importance of addressing the issue of depression. Currently depression is considered to be a major mental health problem
across the life span and the World Health Organisation has estimated that depression is rapidly becoming the world’s biggest population health problem, indicating that the prevention of depression should be a high priority (Murray and Lopez, 1996). The prevention of depression (through early recognition and treatment) should also help to reduce the high rates of deliberate self harm. Different strategies are currently in place addressing depression. These include universal interventions such as public education about depression and school-based programs, which promote optimism and resilience; more targeted strategies which screen and attempt to identify those at increased risk of depression and offering an intervention based on cognitive behavioural principles (Gillham et al, 1995). These strategies require active follow-up by General Practitioners, school psychologists, and mental health services for individuals who remain at high risk for depression following intervention (Patton and Burns, 2002).

**Drug and alcohol abuse**

In this (and other) study(s) drug and/or alcohol abuse emerged as a major contributing factor to a deliberate self harm attempt. It was noted that excessive use of alcohol and drugs can be symptomatic of deeper problems and may exacerbate suicidal behaviour by causing impaired judgement. The presence of alcohol in a large proportion of deliberate self harm attempts in this study suggest that strategies addressing alcohol abuse, in particular in individuals who are experiencing feelings of depression can play an important role in the prevention of suicidal behaviour. Findings from this study suggest that people with a dual diagnosis are of particular risk for suicidal behaviour. This association indicates the potential benefits of coordinating initiatives to combat harmful drug use and deliberate self harming behaviour. Strategies that provide appropriate treatment for these groups will have the potential of decreasing the risk of deliberate self harm. In Australia, harm minimisation (using safer practices to reduce harm) has been the predominant prevention approach. For at-risk individuals, programs are most effective when they are combined with personal and community interventions (Cheadle et al, 1995).

**Clustering of risk factors**

In this study it was suggested that risk factors, particularly in the chronic groups, appear to cluster. This suggests that targeting interventions for one risk factor may bring benefits for others. For example reducing the impact of chaotic family background, may increase academic achievement and reduce levels of anti-social behaviour. Or strategies that address behavioural aspects such as antisocial behaviour, can also have an impact on family and school functioning, as well as other
risk factors, such as substance abuse and suicidal behaviours. Family, school-based and community strategies have proven effectiveness in modifying antisocial behaviour (Toumbourou et al, 2000). Family mediation and family therapy are interventions, which have been effectively used to reduce adolescent antisocial behaviour (Patton and Burns, 2002). Multi-component interventions are most impressive for at-risk individuals. Multisystemic therapy (MST) (Henggeler et al, 1998) targets young people who are at-risk of homelessness and school exclusion and have extreme behavioural problems. MST combines family therapy, parent management training, individual personal competence and enhancement of positive peer relationships with community-based interventions. MST has proven effectiveness in reducing serious antisocial behaviour and substance misuse, improving family relations and increasing school attendance.

**Problem solving, coping and resilience**

Most participants in this study described their attempt as an inability to cope with different situations/feelings. This suggests that people will need to be equipped with the skills to manage stressful situations and cope with emotional disappointments. The impulsiveness of a large number of attempts makes it more difficult to intervene at the time of crisis. Early intervention focusing on building resilience and helping with problem solving as well as communication skills before people reach the crisis point in which they attempt to harm themselves is the best prevention possible as it may alter the behaviour by altering the risk factors. Having universal life skills programs targeting problem-solving skills, healthy coping, interpersonal competence and self-esteem in the whole population can increase their ability to cope. Selective programs, which target higher risk groups, also focus on the development of coping skills, social skills, problem-solving skills and the enhancement of personal well-being and competency. This strategy would promoting resilience and dealing with life stress and risk factors, with strong evidence for longer-term effects. By using interventions that reduce risk factors and build protective factors in individuals, families and communities, the vulnerability to deliberate self harm and suicidal behaviours can be reduced. Such prevention approaches have been successfully applied in areas such as injury prevention, mental health, drug use and prevention of crime and violence (Mrazek and Haggerty, 1994). These areas share many of the same risk and protective factors as suicide, indicating the likely success of this approach for preventing suicide.
Strategies targeting individuals at risk
Follow up for six months after an attempt
It was found that the majority of the participants had made a previous attempt within the six months of their index attempt. This suggests that even after a deliberate self harm attempt they remain vulnerable for a period of time. The follow up of people who have made a deliberate self harm attempt and providing them with appropriate treatment and support for a period of up to six months after a deliberate self harm attempt will have the potential of decreasing the incidence of further deliberate self harming attempts.

Treatment of mental illness
It has been estimated that many people who attempt to harm themselves who had been diagnosed with a psychiatric illness did not receive adequate levels of psychiatric medication for their illness. Studies also suggest that the appropriate use of medication such as clozapine (schizophrenia) and lithium (bi-polar) can reduce suicidal behaviour (Goldney, 2000). Appropriate treatment options for these groups are likely to reduce the incidence of deliberate self harming behaviour.

In addition people who had made a deliberate self harm attempt and were experiencing a major depression or schizophrenia appeared to have difficulties coping with the symptoms of their mental illness as the self harm attempt was expressed as an attempt to ease the pain of their illness. These findings highlight the importance of providing additional support to people who are experiencing difficulties in coping with the disabling symptoms of their psychiatric illness.

Personality disorders
Personality disorders have also emerged as a major risk factor in this and other study(s). Even though people who have personality disorders are considered as being one of the most difficult to treat (Linehan et al, 2000), urgent attention and therapies to treat these disorders are needed as their emotional reactions to minor social stressors are extreme in this group and the underlying feelings of depression are deep and hurtful.

In this study it was also noted that emotional dysregulation appeared to be one of the key factors associated with these groups. Dialectical behavioural therapy has shown to reduce the medical risk of deliberate self harm, number of hospital days, drop out from treatment and anger while improving social adjustment in people with borderline personality disorder (Linehan et al, 2000). Psychotherapy and dialectical behavioural
therapy are some treatment options for these people. Hawton and Van Heeringen (2000b) noted that:

“[Dialectical Behavioural Therapy] represents an important step forward that must help overcome the therapeutic nihilism which many clinicians experience when faced by patients with personality disorders, especially those that engage in suicidal behaviour. Further development may also result from initiatives in which psychological therapies are combined with pharmacological treatments.” (Hawton and Van Heeringen, 2000b p. 719)

One of the difficulties with treating people who belong to these groups is therapist burn out. This burn out is due to different factors, some of which include the difficulties people in this group describe that are often longstanding and little understood. In addition the repetitive nature of the self harm attempts is often interpreted as ‘attention seeking’ and/or ‘manipulative’ by family members and health professionals (Linehan, 2000).

**Dealing with social stressors**

In this study it was discussed that for certain groups of people, it is the catastrophic interpretation of certain events that appears to be associated with the attempt and a cognitive approach can provide valuable coping skills for this group. Some studies have shown that for a selective group of people, cognitive behavioural approaches are effective. These studies were performed on people without drug and/or alcohol addictions or other type of impulsive behaviour such as violence.

**General Conclusions**

Interventions that provide people with the skills to deal with future crises will also reduce the incidence of self harm and/or suicide. Hawton and colleagues voiced the concern that there remains a need for the development of effective treatment for people who engage in deliberate self harming behaviour. The authors noted:

The results of this systematic review indicate that currently there is insufficient evidence on which to make firm recommendations about the most effective forms of treatment for patients who have recently deliberately harmed themselves. This is a serious situation given the size of the problem of deliberate self harm in the world and the importance of dealing with the problem to prevent suicide. (Hawton et al, 1998, p. 444)
The different groups identified in this study and the difficulties coping described by the participants can assist in the development of appropriate therapeutic interventions for people who attempt to harm themselves. This study highlighted the need for different types of treatment for people who engage in suicidal behaviour.
Chapter 9: Conclusions

This final chapter will summarise the results of this study and revisit the most important findings of the research reported in this thesis. I, like many other researchers into suicidal behaviour, have argued that the causes of suicidal behaviour are multi-factorial. A range of risk factors, such as mental health disorders and mental problems, socio-economic disadvantages, family dynamics, substance abuse, impulsive and violent behaviour have been found to be associated with suicidal behaviour in all age groups.

This study focused on the quantitative and qualitative aspects of suicidal behaviour of 90 people who had come to the attention of the Accident and Emergency Department of Westmead Hospital after an attempt to harm themselves. Their accounts of the events leading up to their action were explored in detail in order to gain an understanding of deliberate self harming behaviour. The data was analysed in four stages and included research methods taken from the quantitative as well as qualitative research traditions. Stage 1 involved a narrative structuring and meaning condensation. In this stage all the collected information was entered into comprehensive analytical files. Stage 2 was a descriptive quantitative analysis utilising an SPSS data base. In this stage the known risk factors for deliberate self harm were explored in this sample. Stage 3 of this study focussed on a qualitative analysis of the motives expressed at the time of the event. Stage 4 focused on combining risk factors with circumstances and motive of attempt.

The overall aim of this study was to gain an in-depth understanding of deliberate self harm. The detailed descriptions of the mental states of people who had made a deliberate self harm attempt, highlighted the existence of different subgroups of people who attempt to harm themselves. There are similarities between the identified groups and the literature on deliberate self harming behaviour which lends strength to the existence of these groups. The conclusions reached by this study resonate with the findings of authors such as Sumominen and colleagues (1997), Hamdi and colleagues (1991) and Bancroft and colleagues (1977). These authors focused on different aspects of deliberate self harm and concluded that there were qualitative differences within the phenomenon of suicide. People who attempt to harm themselves want to escape the unbearable Psychache caused by a variety of problems and people who attempt to harm themselves do so to escape the
Psychache they are experiencing. A deliberate self harm attempt could therefore be viewed as ‘a solution to the problem’. This thesis has provided a little more insight into how these ‘problems’ as they were described to by the person making a deliberate self harm attempt.

Ten subgroups were identified in this study. These groups were divided into Acute and Chronic. The acute groups were characterised with an inability to cope with either: a psychiatric illness (groups depression and schizophrenia), social stressors (groups overwhelmed and gain control) or a loss of a relationship or employment (group loss of self). The participants in these groups were unlikely to experience co-morbidity with drug and alcohol abuse and/or personality disorders. Whilst no new risk factors have emerged as important in our understanding of deliberate self harm, participants in the acute group experienced stressful life events of varying intensity or severity, and their deliberate self harm attempt can be interpreted as a failure to cope with these. These findings suggest that people will need to be equipped with the skills to manage these stressful situations and learn how to cope with emotional disappointments. These groups also raise further questions about the role personality and coping in a deliberate self harm attempt, in particular for those where there are no other apparent risk factors (such as drug and alcohol abuse) are present.

The participants in the acute groups described difficulties dealing with issues they were currently presented with, the participants in the chronic groups described longstanding issues. The participants in the chronic groups described their lives as moving from crisis to crisis. Compared to the participants in the acute groups, the participants in the chronic groups were more likely (although not exclusively) to describe their family of origin as chaotic and to report a history of abuse, often occurring during their childhoods. Personality disorders were also more likely to occur in the in the chronic groups. The issues that are described in the chronic groups are longstanding and multiple. The attempt to self harm was made in the context of these multiple issues. These issues included depressed feelings brought to the foreground by drug or alcohol abuse (group drug and/or alcohol abuse), feelings of rejection (group low self worth), feelings of self hatred (group self hatred) and underlying feelings of disconnectedness (group disconnection). There is support in the literature for the existence of these groups and the clusters of risk factors which emerged in this study within the chronic groups (in particular the clusters: adverse childhood experiences, violent and impulsive behaviour, drug and/or alcohol abuse and personality disorders).
The identification of subgroups of deliberate self harm is an important area of research. Hawton and Van Heeringen (2000b) noted:

There has been an understandable move towards delineation and investigation of subgroups of suicides and suicide attempters. These include for example groups defined according to the nature of psychiatric of personality disorders and also groups defined by age group. Such an approach has helped to identify risk factors for suicidal behaviour in, for example, individuals with depression, schizophrenia, and alcohol abuse disorders. It has also facilitated awareness of risk factors that are specific to the young and the elderly. This will continue to be a valuable direction for research, although the limitations inherent in the search for risk factors for suicidal behaviour […] must always temper the extent to our expectations. However this avenue of research should increase our awareness of specific treatment approaches and prevention strategies for subgroups of individuals.” (p.718)

The subgroups identified in this study will need to be confirmed by larger studies as the numbers in this sample are relatively small and are taken from one hospital in the Western Suburbs of Sydney, Australia. Each of the groups may lend itself to particular prevention and/or therapeutic strategies, some of which were discussed in the previous chapter. Some of the strategies discussed included:

- Strategies targeting individual risk factors such as depression, antisocial behaviour, alcohol and drug use problems, impulsive behaviour, problem solving skills and coping strategies as well as poor family cohesion, family conflict and/or child abuse.
- Strategies that enhance protective factors such as resilience and coping strategies.

This research focussed on exploring the possibility of subgroups of deliberate self harm, and further research is needed to test and revise the suggested groupings. The following are some suggestions are made for areas for future research, this list is not intended to be exhaustive:

- Further research is needed to confirm and refine the identified subgroups;
- Further research is also needed to investigate why some people when faced with similar circumstances attempt to harm themselves and others do not; The protective mechanisms for suicidal behaviour are likely to provide a
valuable insight into our understanding of suicidal behaviour as well as into the development of therapeutic interventions for these people;

- Further development of different therapeutic interventions aimed at specific people in different groups who attempt to harm themselves and further development of brief interventions for people who attempt to harm themselves;

- Participants in the chronic groups have been identified as being difficult to treat and further research is needed to develop effective treatments for individuals who are part of the chronic groups; and

- Further development of potential pharmacological treatments for suicidal behaviour and ideation.

**Concluding remarks**

The people who were interviewed in this study all had made an attempt to harm themselves to escape unbearable feelings of Psychache. For some these feelings only lasted a few minutes, whereas for others the thinking was more longstanding and deliberate; however, as was described in this thesis, the state of mind described at the time of the event, for all the respondents across all groups was associated with an unbearable Psychache. A deliberate self harming behaviour can have very serious unwanted consequences which can lead to death or serious physical injuries. The majority of the participants in this study, if circumstances had been slightly different could have easily died as a consequence of their self harm attempt. This highlights the need to take all deliberate self harm attempts seriously, regardless of the lethality the methods or whether an intention of death is expressed. All people who attempt to deliberately harm themselves, whether this is intended or not, are at risk of dying as a result of their action⁴⁸.

Given the complexity of deliberate self harming behaviour, the often impulsiveness of the act and the high rates of deliberate self harm in most western countries, it is very easy to become pessimistic about our ability to prevent further deliberate self harm attempts. However it is the authors firm belief that the prevention of suicide is possible. People who attempt to harm themselves often are trying to find a solution to their problem. People who participated in this study had in common the fact that their thinking had been impaired either by factors such as mental illness, poor coping

⁴⁸ Two people interviewed for this study had died by the time this thesis had been written. Both belonged to the chronic group and had expressed their intention as wanting time out from their feelings.
skills, stress, drugs and/or alcohol or anger. To many of us who have never experienced this extreme state of mental pain, deliberate self harm might appear to be a wish to end one’s life. However the vast majority of the people in this study described their attempt as a way of coping with the different problems or situations they were facing. To many the deliberate self harm attempt, was not a longing for death, but a desire to live a life free from the pain experienced.

People who attempt to harm themselves are feeling overwhelmed and are unable to see any other way out. If other solutions are provided to deal with their psych ache, less people will resort to trying to harm themselves as a solution to their problems. As RP 73 explained:

I honestly don’t believe I wanted to die. Because I didn’t plan to take the pills or anything like that, I just wanted to get away from it, you know? You want to get away from something and you don’t know how to do it? When I was laying here I was thinking, ‘Why did you do it?’ You know? And then I got to thinking, ‘Well, you couldn’t see any other way out’. It was the only way I had of escape. Just to take a few pills. (RP 73)

By developing strategies and treatments for the problems as they were identified in this study and by raising the awareness that there is help available for these different issues, we may be able to reduce the pain which results in an attempt to self harm. The majority of people who attempt to harm themselves are wanting a better life, not to end their life and if we are able to support and understand people who attempt to harm themselves we may be able to lessen some of their pain.
Bibliography


Baume, P. (1996) Suicide in Australia; do we really have a problem. The Australian Educational and Developmental Psychologist, 13 (November).


Appendixes

Appendix 1: Interview outline

Background identifying information
Age and gender
Country of origin and languages spoken at home
Relationship status
Education
Occupation

Events leading up to hospital admission
What were the events?
Meaning and motivation of attempt
What happened in mind at the time of attempt
Time of suicidal thoughts
Intention of attempt (i.e. death, time out etc.)
Feelings about attempt

Past suicidal behaviour
Suicide thoughts, frequency
Differences between this attempt and suicidal thoughts. What made them act
Understanding of past attempts, triggers for self harm

Personal History
Work history
Marital history
Relationship with others
Children
Living conditions
Life events in past 12 months

Family history
Upbringing and parental relationship
Parental psychiatric history and/or suicide

Previous medical history
Physical health
Drug history
Present and previous drug use
Use of drugs, under what circumstances

Pre-morbid personality
Overall mood and temperament before attempt
Character traits
Social relations with family, friends and workmates

Help seeking
Who have they spoken to in regards to suicidal thoughts
Help seeking behaviour

Present contact with health services/welfare services
Experience with these health professionals
What they thought of help received
What they would have liked

Future hopes
Future plans
Reinforcement of positive aspects

If not collected by the registrar
Mental health assessment
Personality
Physical appearance
Eating pattern, appetite, sleeping pattern and weight changes
Ability to cry
Memory loss
Speech
Hallucinations and disorientations
Appendix 2: Template for case notes research participant

**Background identifying information**
Age and gender
Country of origin and languages spoken at home
Marital status
Education
Occupation
Method

**In regards to the events leading up to hospital admission**
What were events:
Meaning and motivation of the attempt
What happened in their minds when attempt happened.
Intent of suicide attempt (i.e. death, time out etc.)
Feelings about attempt
Past self harming behaviour
Suicidal thoughts, frequency
Difference between this attempt and suicidal thoughts. What made them act.
Understanding of past attempts, triggers for self harm

**Help seeking behaviour**
Who have you spoken to about your suicidal thoughts
Help seeking behaviour

**Personal History**
**Work history**
Marital history
Relationship with others
Children
Living conditions

**Previous medical history**
Physical health
Present contact with health services/welfare services
Experience with these health professionals
What they thought of help received
What they would have liked
Previous contact with health services
Prior admission to hospital
Ongoing treatment, medication
Future utilisation of health services

Drug history
Present or previous drug use
Use of the drugs, under what circumstances

Pre-morbid personality
Overall mood or temperament before attempt
Character traits
Confidence
Religious and moral beliefs
Ambitions and aspirations

Social relationships with family, friends and workmates
Family history
Family psychiatric illness

Coping ability
Past coping strategies
Difference in circumstances
Transposition of coping strategies

Future hopes
Future plans - Hopeful about the future
Reinforcement about positive aspects.
Mental health assessment
Personality
Physical appearance
Self confidence
Eating pattern, appetite, sleeping, weight changes
Ability to cry
memory loss
Speech
Hallucinations or disorientation

Interventions given:
Diagnosis
Appendix 3: Items entered into SPSS.

Interview details
Time between awakening and interview
Less than 12 hours
12 to 24 hours
24 to 48 hours
2 days to 1 week
more than 1 week

Interview with psych
Yes
No

Interview with translator
Yes
No

Place of interview
Emergency Department
Ward
ICU
Private room

Background information:
Actual age

Age in brackets
17 to 24
25 to 34
35 to 44
45 to 54
55 to 65
65 +
Gender
Male
Female

Relationship status
Never married/single
Married
De facto
Boyfriend/girlfriend
Separated
Divorced
Widowed

Relationship status 1 month prior to attempt
Never married/single
Married
De facto
Boyfriend/girlfriend
Separated
Divorced
Widowed

Relationship status at time of attempt
Never married/single
Married
De facto
Boyfriend/girlfriend
Separated
Divorced
Widowed

In relationship 1 month prior to attempt
Yes
No
In relationship time attempt
Yes
No

**Occupation**
Professional
Blue collar
White collar
Sickness benefits/Pension
Disability pension
Unemployed
Home duties
Student

**Highest education obtained**
Year 10
HSC
University degree
Post graduate degree
TAFE

**CALD**
Yes
No

**Indigenous**
Yes
No

**Children**
Yes
No

**Children in care**
Yes
No
No children

**Age of children**
Under 10
10 to 18
Over 18
No children

**Details of attempt:**
**First attempt**
Yes
No

**Loss of consciousness**
Yes
No

**ICU**
Yes
No

**Lasting physical impairment because of attempt**
Yes
No

**Method**
Overdose Psych medication
Overdose Other medication
Overdose poison
Hanging
Shooting
Stabbing
Cutting
Car exhaust
Jumping
**Place of attempt**
Own home
Home of friend
Hospital
Public space

**Time of suicidality**
Less than 5 minutes
5 to 10 minutes
10 to 20 minutes
20 to 30 minutes
30 minutes to 1 hour
1 to 3 hours
3 to 6 hours
6 to 12 hours
12 to 24 hours
24 to 48 hours
> 48 hours

**Attempt under influence of alcohol (not including drink for courage)**
Yes
No

**Attempt under the influence of drug and alcohol (including withdrawing)**
Yes
No

**Suicide note**
Yes
No

**Social stressor at time of attempt**
Yes
No
Representation to hospital?
Yes
No

Previous attempts
Previous attempt
No previous attempts
Previous attempt (< 1 week)
Previous attempt (1 week to 1 month)
Previous attempt (1 to 3 months)
Previous attempt (3 months to 6 months)
Previous attempt (6 months to 1 year)
Previous attempt (1 to 5 years)
Previous attempts (more then 5 years)

Number of previous attempts
1
2
3
4
5
More then 5
None

Patterns of attempt
First attempt
Continual throughout life
Only when having an episode of mental illness
One previous attempt in the distant past (more than 10 years)
Previous attempts when in similar crisis (long spaces between)
No attempts prior to this period of crisis

State of mind at time of interview
Same
Same (no impulse to harm)
Shift of mindset
Intent
Confused by alcohol/other drugs
Confused by mental illness/state
Stop the depression
Stop the voices
Death is easier than dealing with the problem
Wanting time out from way they have been feeling
To sleep/to get away
Life is too difficult
Wanting to be taken care of
Feeling rejected
Like a paper bag that just exploded
Did not admit to attempt

Social stressors
Relationship difficulties
Yes
No

Death of partner
Yes
No

Loss of job
Yes
No

Threat of prison
Yes
No

Health preoccupations
Yes
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Contact with health department for psychiatric history
Yes
No
No psychiatric history

Psychiatric diagnosis
Axis 1 diagnosis
Yes
No

Depressive disorder
Yes
No
No Axis 1

Type of depression
Major depression
Major depression ddx early onset schizophrenia
Major depression psychotic feature
Partially treated major depression
Adjustment disorder with depressed mood
Depression not otherwise specified
Dysthymia
Melancholic depression
Depressed thinking after a grand mal fit
Heroine induced mood disorder
Bi-polar depressed state
Bi-polar manic state
No mood disorder
Paranoid depression
Post-natal depression
No Axis 1 diagnosis

Psychotic disorder
Yes
No
Type of disorder
Psychosis
Schizophrenia
Drug induced psychosis
No psychotic disorder

PTSD
Yes
No

Anxiety disorder
Yes
No

Learning disability
Yes
No

Axis 2 diagnosis
Yes
No

Borderline
Yes
No
No axis 2

Dependant
Yes
No
No axis 2

Anti-social
Yes
No
No axis 2
Narcissistic
Yes
No
No axis 2

Paranoid
Yes
No
No axis 2

Avoidant
Yes
No
No axis 2

Drug and alcohol abuse
Yes
No

Alcohol
Yes
No
No D and A

Heroin/speed
Yes
No
No D and A

Marijuana
Yes
No
No D and A
Prescription medication
Yes
No
No D and A

Methadone
Yes
No
No D and A

Family history
Chaotic family background
Yes
No
Unknown

Family history of psychiatric illness
Yes
No
Unknown

Family history of depression
Yes
No history
Unknown

Family history of psychotic illness
Yes
No history
Unknown

Family history of PTSD
Yes
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<td></td>
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**History of abuse**
- Yes
- No
- Unknown

**History of physical abuse**
- Yes
- No
- Unknown
- No abuse

**History of sexual abuse**
- Yes
- No
- No history
- Unknown

**History of adult trauma**
- Yes
- No
- Unknown

**Physical assault by partner**
- Yes
- No
- No history
- Unknown

**Sexual assault by partner**
- Yes
- No
- No history
- Unknown
Sexual assault by stranger
Yes
No
No history
Unknown

Emotionally distant parents
Yes
No
Unknown

Pathway
Acute
Chronic
Appendix 4: Dominant characteristics

Acute psychiatric

Acute: psychiatric (depression)
- Attempt described as deliberate and related to coping with their mental illness.
- No lessening of the pain and confusion after the event.
- Diagnosed with major depression or bi-polar disorder.
- No diagnosis of personality disorder.
- No history of abuse.
- No drug and/or alcohol abuse.
- No forensic history or violent behaviour.
- Mainly in their mid adulthood.

Acute psychiatric (schizophrenia)
- Attempt described as impulsive and described as related to a confused state of their illness or to stop the symptoms/voices relating to their illness.
- None were suicidal at the time of the interview and the distressing presence of the voices had disappeared; however no lessening of the pain or confusion experienced.
- Diagnosed with psychiatric diagnosis of schizophrenia.
- Violent behaviour and drug and alcohol issues associated with psychiatric illness.
- Social stressors related to their living with their illness.
- Mainly young adults.
Acute social stressor: impulsive

This group was subdivided into two namely Overwhelmed and Gain control.

Acute social stressors: impulsive (overwhelmed)
- Attempt described as impulsive to have time out from the stressors in their life and/or stressed state of mind.
- Cathartic effect on mental state; all felt that they were able to cope with their issues again after the event.
- Psychiatric diagnosis of adjustment disorder with depressed mood.
- No personality disorder.
- No difficulties with anger.
- No violent behaviour.
- No drug and alcohol abuse.
- Stable childhood, and good functioning prior to their attempt.
- Mainly mid adulthood.

Acute social stressors: impulsive (gain control)
- Attempt described as impulsive reaction to a fight with significant other to gain control over the situation.
- Pain and confusion experienced had lessened the next day.
- Diagnosed with adjustment disorder with depressed mood.
- Good functioning prior to the attempt.
- No personality disorder.
- No drug and alcohol abuse.
- No violent or aggressive behaviour.
Acute social stressors: non impulsive (loss of self)
- Attempt described as deliberate and associated with feelings of loss of self; life was not worth living because of social stressors they were dealing with. Depressed feelings were described as a response to social stressor (mainly a relationship breakdown).
- Event did not alter pain and confusion experienced.
- Psychiatric diagnosis of depression.
- Half of the people in this group were also diagnosed with a personality disorder (mainly borderline and dependant).
- No violent behaviour.
- No forensic history.
- No drug and alcohol abuse.

Chronic: drug and alcohol
- Attempt made under the influence of drugs and/or alcohol. The circumstances of the attempt varied according to the drugs utilised and this group was separated into three subgroups.
- Psychiatric diagnosis of adjustment disorder.
- Diagnosis of personality disorder.
- Drug and alcohol abuse.
- Forensic history.
- Chaotic and abusive childhoods,
- Difficulties with anger and violent behaviour.
- Mid adulthood.
**Chronic drug and alcohol impulsive (alcohol)**
- Attempt described as impulsive. None were feeling suicidal prior to their drinking and most stated that they were too drunk at the time of the attempt to remember what they intended.
- No suicidal feelings when sober.

**Chronic drug and alcohol impulsive (drug induced psychosis)**
- Impulsive attempt whilst experiencing a drug induced psychosis.
- No suicidal feelings once the effects of the drugs disappeared.

**Chronic drug and alcohol non impulsive (withdrawal)**
- Deliberate attempt during withdrawal from speed or heroin. Had been thinking about harming themselves for quite some time.
- Feelings present at the time of the interview.

---

**Chronic: social stressors**

**Chronic social stressor impulsive**
- This group was separated into two in regards to the events leading up to the attempt. Had very similar background characteristics.
- Diagnosed with adjustment disorder.
- Associated personality disorder.
- Drug and alcohol abuse.
- Chaotic and abusive childhoods.
- General difficulties functioning throughout their lives.
- Anger and violent behaviour with a forensic history.

**Chronic: social stress (low self worth)**
- Impulsive attempt under the influence of drugs and/or alcohol as a response to a fight with a significant other. Attempt described as a response to feeling rejected and hurt by the others’ behaviour and wanting to show them how hurt they were feeling.
- No suicidal feelings after the event.
Chronic social stress (self hatred)
- Impulsive in response to a social trigger which activated feelings of self-hatred. The attempt was described as a way to escape these feelings.
- No suicidal feelings after the event for most, however still had mixed feelings about their lives.

Chronic social stress: non impulsive (disconnection)
- Attempt described as deliberate and being outside of their control and related to general feelings of disconnectedness with the world.
- Suicidal feelings not present at the time of the interview but, general feelings of disconnectedness remained.
- Mild to moderate levels of depression.
- Associated diagnosis of borderline personality disorder.
- History of abuse, mainly single events that occurred outside of the family of origin.
- Parents described as emotionally distant.
- Mainly younger females.
**Appendix 5: Family history of suicide**

Table a.1 Family history of suicide/deliberate self harm

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<td>54.4</td>
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Table a.2: Family member who attempted suicide/deliberate self harm

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Understanding deliberate self harm: an enquiry into attempted suicide

Marianne Wyder

October 2004

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy.

School of Applied Social and Human Sciences
University of Western Sydney
This thesis is submitted in fulfilment of the requirements of a degree of Doctor of Philosophy at the University of Western Sydney. I declare that this thesis is my own account of my research and has not been submitted previously for a degree at any other university of institution.
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Abstract

This study focused on the quantitative and qualitative aspects of suicidal behaviour of 90 people who had come to the attention of the Accident and Emergency Department of Westmead Hospital after an attempt to harm themselves. Their accounts of the events leading up to their action were explored in detail in order to gain an understanding of deliberate self harming behaviour. The data collected in this research was analysed using research methods taken from the quantitative as well as qualitative research traditions. A descriptive quantitative analysis was undertaken and known risk factors for deliberate self harm were explored. Secondly a qualitative analysis of the motives expressed at the time of the event undertaken. Lastly the risk factors identified in the study were combined with the circumstances and motive of attempt.

Participants were regrouped according to whether the problems the respondent described were chronic (longstanding) or acute (pivotal). The participants in the acute groups described difficulties dealing with issues they were currently presented with. The participants in the chronic groups described longstanding issues. In contrast the participants in the chronic groups described their lives as moving from crisis to crisis. Compared to the participants in the acute groups, the participants in the chronic groups were more likely (although not exclusively) to describe their family of origin as chaotic and to report a history of abuse, often occurring during their childhoods. Personality disorders were also more likely to occur in the in the chronic groups.

The participants were further classified according to the persistence of thoughts of self-harm (impulsive or non impulsive/deliberate) and the presence or absence of these feelings at the time of the interview (the resolution of the attempt) and the types of problems/situations and triggering events the person described as wanting to escape. Ten subgroups were identified in this manner. Those who belonged to the acute subgroups described their attempt as inability to cope with either: a psychiatric illness, social stressors or a loss of a relationship or employment. The issues that are described in the chronic subgroups are longstanding and multiple. The self harm attempt was made in the context of these multiple issues. These issues included depressed feelings brought to the foreground by drug or alcohol abuse, feelings of rejection, feelings of self hatred and underlying feelings of disconnectedness.

By developing strategies and treatments for the problems as they were identified in this study and by raising the awareness that there is help available for these different issues, we may be able to reduce the pain which results in an attempt to self harm.