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A Qualitative Analysis of Perceptions of Self-Harm in Members of the General Public.

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Abstract.

Purpose: Previous research into health care professionals' perceptions of self-harm has found that, although complex, in some cases, their perceptions can be somewhat negative and unsympathetic towards individuals who harm themselves. However, it is presently unclear whether these perceptions reflect more general attitudes to self-harm in broader social groups. The present study represents a preliminary investigation into perceptions of self-harm in the general public. Firstly, since there is no universal agreement on which behaviours constitute self-harm, this study aimed to investigate public perceptions of this, including whether participants identified more controversial behaviours such as eating disorders and body modification as methods of self-harm in addition to the more commonly identified behaviours such as cutting and burning. Secondly, it aimed to identify whether attitudes towards individuals who self-harm in a small sample of the general public were similar to the sometimes negative and unsympathetic perceptions of health care professionals demonstrated in some previous studies.

Design/Methodology/Approach: Semi-structured interviews were conducted with seven participants, none of whom had any professional or academic experience or knowledge of self-harm, who were recruited via second acquaintances of the first author. A

matrix based thematic analysis method was used to analyse the data collected.

Findings: The main findings of this study were that eating disorders were generally perceived as forms of self-harm while body modification was not, and that participants generally showed sympathy towards individuals who self-harm, especially when they perceived the behaviour to be associated with mental illness.

Originality/Value: Although, given the small size of the sample, this should be considered a preliminary study, our findings suggest that developing a greater understanding of public perceptions of self-harm could have important implications for understanding mental health professionals' perceptions of the phenomenon. We suggest that stigma and negative perceptions of people who self-harm may not be inevitable and that further research in this area could be of value in informing public and professional education campaigns in this area.

Keywords: Self-harm, Health-care professionals, Eating disorders, Public attitudes, Thematic analysis.

Introduction.

There is a wealth of research on self-harm within a variety of different disciplines, including anthropology, sociology and especially both psychology and public health. However, since different disciplines consider the phenomenon from different theoretical viewpoints, this has contributed to a lack of professional consensus on self-harm. Here we consider the phenomenon from a largely psychological perspective and so we focus on the psychological literature on self-harm. There is a wide range of terminology used throughout this literature: For example the phenomenon has been variously described as; Self-Harm, Self-Injury, Self-Mutilation, Deliberate Self-Harm, Self-Inflicted

Violence and Self-Injurious Behaviour (Sutton, 2007). However, since the most common term in the psychological literature appears to be 'Self-harm' we have also adopted it. In addition to the myriad terminology used, there is also a lack of consensus regarding the phenomenon of self-harm and what it actually is. Due to this, there is no universally agreed upon definition of self-harm in the literature and so it is defined in a number of conflicting ways (Mangnall & Yurkovich, 2008). For example, McAllister (2003, p.178) defines self-harm as: "any act that causes psychological or physical harm to the self without a suicide intention, and which is either intentional (or) accidental..." However, Mangnall and Yurkovich (2008, p.176) disregard psychological harm and instead claim that self-harm is a:

"direct behaviour that causes minor to moderate physical injury, that is undertaken without conscious suicidal intent, and that occurs in the absence of psychoses and/or organic intellectual impairment."

Thus there is some disagreement as to whether self-harm need be intentional, or can also be accidental. Sutton's (2007) opinion of self-harm also contrasts with McAllister's (2003) definition as Sutton (2007) suggests that the act of self-harm occurs in order to *express* severe psychological distress rather than causing it. However, in accordance with many other definitions of self-harm, Sutton (2007) does accept that self-harm is carried out only when there is a lack of suicide intention.

Another widely debated issue in regards to the complex phenomenon of self-harm is which particular behaviours are thought to constitute it. Throughout the psychological literature of self-harm, different harmful behaviours are interpreted in different ways (Laye-Gindhu & Schonert-Reichl, 2005). For example, Favazza (1996) claims that in some cultures, certain harmful behaviours, such as piercing, branding and circumcision are accepted as cultural rituals or societal rites of passage and because of this, these behaviours are not considered to be self-harming behaviours. Instead, they are thought to be linked to physical healing and spirituality and not psychiatric disorder. Similarly, McAllister (2003) suggests that since tattoos and piercings

are normative in some cultures they should not be considered pathological. Instead, she suggests that a behaviour should only be considered pathological when it goes against cultural norms; for example, cutting the skin. Both Emerson (2010) and Motz (2009) claim that cutting is one of the most common methods of self-harm, though other methods include burning, scratching, head-banging, starvation, drug-taking and intense exercise (Skegg, 2005). Rayner and Warner (2003) also include socially sanctioned behaviours, such as tattooing and piercing in their definition of the term self-harm.

There is also the question of whether or not anorexia and bulimia should be considered forms of self-harm or whether eating disorders constitute a completely separate psychological phenomenon. According to Strong (1998, p.117) "...the two behaviours share many of the same roots and serve many of the same functions". However, whilst the DSM-IV (American Psychiatric Association, 2000) includes distinct diagnostic criteria for anorexia, deliberate self-harm exists only as a symptom of Borderline Personality Disorder (BDP). This suggests that the mainstream of psychiatric professionals do not yet recognise self-harm as a distinct psychological disorder in the same way that psychologists often do. For example, Motz (2009) argues that people who perform harmful behaviours on themselves have clear positive intentions, such as self-preservation and the communication of inner distress. She suggests that acts of self-harm are carried out by choice and not as an undesirable symptom of an involuntary disorder. It is therefore unclear whether simply reducing self-harm to a symptom of a personality disorder represents an adequate response to the phenomenon. Furthermore this distinction between the psychiatric classification of eating disorders versus self-harm seems to be reflected in general societal perspectives on these phenomena; whilst eating disorders are widely classified as an illness (Sansone & Levitt, 2002), self-harm is often viewed as attention seeking behaviour (McAllister et al, 2002). This may be important since the way in which people conceptualise a psychological phenomenon may have consequences for the ways in which they behave towards individuals who exhibit it.

This view of self-harm as an act of attention-seeking is evident not only throughout wider society but also among some health care professionals (Law et al, 2009). In response to some patients who self-harm expressing their unpleasant experiences of some health care settings such as Accident & Emergency departments (Harris, 2000), a growing body of research has been carried out into the perceptions and responses of health care professionals towards people who self-harm. Although there are specific psychiatric services which have been set up over recent years to help individuals who self-harm by providing fully trained professionals to help and support them (Strong, 1998), these psychiatric services are very rarely the first source of help for a person who has committed an act of self-harm (Hadfield et al, 2009). More often, A&E departments will be the first point of contact after an episode of self-injury. For this reason, it has previously been important to study perceptions of A&E doctors and nurses to understand how their treatment of patients who self-harm may impact on future harmful behaviours (Hadfield et al, 2009). A number of these studies have found that in some cases, some health care professionals' responses to people who self-harm can be somewhat negative and unsympathetic (Law et al, 2009). For example, Harris (2000) conducted a qualitative correspondence study in which she contacted individuals who self-harm and asked them to describe their personal experiences in A&E departments. Several of the women in Harris' study expressed traumatic and unpleasant experiences in A&E following acts of self-harm. These experiences included a lack of sympathy from doctors and nurses, being humiliated by staff, and being told they were wasting staff time and that they were selfish for not considering the patients who really were ill. These traumatic experiences may have negative effects on individuals who self-harm by reinforcing their own feelings of shame and self-hatred which may in turn contribute to further acts of self-harm (Harris, 2000).

Interestingly, Hadfield et al. (2009) also studied A&E staff's perceptions of self-harming patients. They carried out a qualitative study on A&E doctors'

experiences of treating people who self-harm. They found that the A&E doctors interviewed often felt powerless when treating patients who had self-harmed because they felt unable to offer effective help. Due to this, they sometimes trivialized and dismissed the persons self-harm in order to address their own feelings of powerlessness and discomfort. However, these researchers also found that when doctors believed the reason for the patients' self-harm was to gain attention, they "considered the person who had self-harmed to be undeserving of treatment" (Hadfield et al, 2009, p.760). Some of these doctors felt that by offering treatment they were giving in to the demands of people who self-harm for attention. On the other hand, many of the doctors in this study believed that if the individual who self-harmed had been diagnosed with a psychiatric disorder, their reasons for receiving treatment were valid since the harming behaviour was not really their fault (Hadfield et al, 2009).

However, Johnstone (1997) suggests that labelling an individual who self-harms with a psychiatric disorder is often negative as it can lead to stigma. She also claims that once a psychiatric label has been placed on an individual, medical staff may no longer see the person as separate from the disorder (Johnstone, 1997). Furthermore, Emerson (2010, p.841) points out that it is not only some medical staff who cannot see past the label of mental illness but "the general public still affix the label of mental illness to someone inflicting pain on themselves" . This stigmatizing label may have a negative impact on an individual who self-harms' life by lowering their self-esteem and also by affecting how they act after an episode of self-harm (Emerson, 2010).

In order to reduce the stigmatizing labels placed on individuals who self-harm, various other reasons for engaging in self-harming behaviours need to be examined within society (Law et al, 2009). Rayner and Warner (2003) conducted a quantitative study which aimed to identify public perceptions of the underlying functions of self-harm. They found that the general public believed that individuals may self-harm to reduce depression or anxiety, isolation or loneliness, to feel more in control of their lives, as a distraction from other problems or emotional pain and as a response to negative feelings towards the

self, including self-hatred and self-anger. They also found that their participants did not generally perceive self-harm as a mental illness. These perceptions of the various functions of self-harm demonstrate an awareness that self-harm can be caused by any number of factors. It is not necessarily a symptom of a psychiatric disorder and so individuals' who partake in self-harming behaviours should not all be tarred with the same psychiatric brush.

Although an extensive amount of research has been conducted on self-harm, with the exception of Rayner and Warner's (2003) study, little research has been carried out on how self-harm is perceived by the general public. This represents an important limitation to our present understanding of attitudes toward self-harm. For example, it is unclear whether the sometimes negative perceptions of some health care professionals towards people who self-harm are shared by the wider public, or instead reflect the fact that practitioners are often dealing with these individuals in stressful, high-pressure situations (O'Donovan & Gijbels, 2006, Duperouzel & Fish, 2007). It may be the case that these often overwhelming situational demands drive professional perceptions of self-harm as an attention seeking behaviour, or it may be that these simply correspond to the general view of self-harm shared by the wider public. Data on this issue could have important implications for education and training in health care designed to help professionals effectively deal with self-harm. Furthermore, a greater understanding of public perceptions of self-harm might contribute to our understanding of the stigma surrounding this phenomenon. This stigma may in itself be damaging in terms of discouraging people who self-harm from seeking help and treatment, and so a greater understanding of it might be invaluable as a first step to raising awareness and empathy in both the general public and health professionals.

A further limitation of much of the previous research into both public and professional perceptions of self-harm is that it often utilises quantitative methods (Rayner & Warner, 2003; Mackay & Barrowclough, 2005; Law et al, 2009;). This is potentially problematic given that the measures employed will be strongly influenced by the specific definition of self-harm adopted, and this will

necessarily limit participants' responses accordingly. In contrast, our research employed semi-structured interviews and a qualitative analytical approach to understand our participants' views of self-harm from their own subjective positions. Our aim was to investigate public perceptions of self-harm with a particular focus on issues surrounding stigmatisation, motivations for self-harm and perceptions of the specific behaviours which constitute it.

Method.

Study sample.

The study sample consisted of seven participants aged between 23 and 73. Three participants were female. Participants were recruited by asking personal acquaintances of the first author to refer individuals who might be willing to take part. Since we were interested in general perceptions of self-harm rather than specific experiences, and for ethical reasons, we excluded individuals who reported having previously self-harmed or who were aware of self-harming behaviour in their close friends or family. We also excluded Psychology students and public health professionals, since we were interested in the views of individuals with no formal knowledge of academic theory and research surrounding self-harm. The study was reviewed by the University of Huddersfield, Division of Psychology and Counselling ethics panel before any participants were approached.

Procedure.

Semi-structured interviews were utilised to allow us to flexibly explore our participants' in-depth perceptions of self-harm.

The interview schedule was developed with the intention of gaining an insight into the attitudes of the individuals in our sample towards self-harm but also with the intention of collecting as much rich data as possible. Eighteen interview questions were devised around the different issues of interest, which included asking our participants; 'What do you know about people who self-harm?',

'What do you think people are trying to achieve by self-harming?', 'How responsible do you think people are for their self-harm?', 'Do you think anorexia and bulimia are methods of self-harm and if so, why?', 'What do you think about people who have lots of tattoos and/or piercings? Would you consider these to be forms of self-harm?' 'How do you feel about people who self-harm?', 'Do you personally believe that self-harm is the result of a mental illness?' Participants' personal feelings and perceptions of people who self-harm were elicited in order to compare them with the health care professionals' personal attitudes found in previous studies. Care was taken to devise the interview schedule in such a way as to explore participants' perceptions without directing them by implicitly conveying the attitudes of the interviewer. Interviews were carried out by the first author and varied somewhat in length, but typically lasted between twenty and thirty minutes.

Data analysis.

All seven interviews were transcribed verbatim and then analysed using a matrix based thematic analysis method (Ritchie et al, 2003). The first step of this analysis involved reading and re-reading the transcripts in order to get an overview of the data. Descriptive and interpretative codes were then developed which facilitated the identification of emerging themes (King & Horrocks, 2010). A thematic framework was then used to effectively organise and manage the data for each theme in terms of its constituent sub-themes. The development of each thematic frame involved setting out a table with a column for each sub-theme and a row for each participant in the study. We then went through each interview transcript and picked out examples for each sub-theme from each interview. The examples for each sub-theme were then added into the appropriate row under the relevant sub-theme (King & Horrocks, 2010). This framework made it easy to systematically review the data throughout the analysis stage without obscuring the raw data (Ritchie et al, 2003) and it also provided an effective way for us to visually represent the data collected (King & Horrocks, 2010).

Findings.

For the purposes of the discussion, the 7 participants are referred to as P1 – P7. There were four key areas which were of interest in the analysis of the data collected. These areas were; ‘Public display of behaviours’, Personal and Societal Attitudes’, ‘Self-harm as a mental illness’ and ‘The motivation to self-harm’.

Participants were asked questions regarding their perceptions of Eating disorders and body modification. They were also asked which behaviour they perceived to be worse. When participants were asked “Do you think Anorexia and Bulimia are methods of self-harm and if so, why?”, 6 out of the 7 participants interviewed regarded anorexia and bulimia as forms of self-harm. P1 stated that although anorexia is not the expected form of self-harm, i.e. self-cutting, it is still an act which is harmful to the body. However, some participants believed that the functions of self-harm and eating disorders differed. For example, P4 believed that as cuts leave obvious marks, they could be interpreted as a cry for help,

“...whereas bulimia and anorexia might be more internal...where the persons dealing with it on their own...cutting their selves is...like making the choice between showing definite signs”.

These findings suggest that in general, our sample regard eating disorders to be a different method of self-harm. These findings support research by Stanford & Jones (2010) study which concluded that adolescents also regard starvation as a form of self-harm.

When participants were asked about the severity of self-harm it was found that participants’ perceptions of which behaviours they perceived to be most serious seemed to depend on which behaviours they believed were more visibly displayed to others. This was indicated by 5 out of 7 participants. When P1 was asked ‘Which (behaviour) would you regard as worse?’, her response was :

“Probably cutting yourself, just because you’ve got the physical scars...they’re not going to heal...they’re never going to go away. I know it’s the same with like, bulimia and anorexia but I think...other people can see the scars they can’t see...someone...not eating...but if you looked at someone and the first thing you saw were cuts down their arm, you know big gashes down their arm, you’d think oh my God, but with things like anorexia and bulimia it’s not something that you see straight away”.

On the other hand, where eating disorders were perceived to be more noticeable to other people, they were perceived as worse behaviours. For example, when P2 was asked which behaviours he regarded as worse, his response was:

“I’d say anorexia ‘coz it’s noticeable to other people, self-harm...like for example you cut your arm or something you can hide it...but anorexia you can’t hide...”

These findings are interesting as it appears that the severity of self-harm is not judged by the severity of the threat to the individuals’ health. Instead it seems that these participants have judged the severity of self-harm by how observable the act is to them. These findings are of particular interest as it could be assumed that anybody who goes to extreme lengths to hide their self-harm poses a higher risk to themselves than somebody who does not try so hard to hide their destructive behaviour. The findings also have implications for the issue of self-harm as an attention seeking behaviour. Participants seem to be judging the severity of self-harm based on the amount of attention it elicits from others.

Interestingly, 3 out of 7 participants said that everything they knew about self-harm came from watching television programmes. For example, when P2 was asked what he knew about people who self-harm, he replied;

“Not much really...basically just through what I’ve seen and heard on telly and that.”

With this in mind, it may be that what these participants perceive as more noticeable behaviour simply reflects the behaviours they have witnessed on the television.

Questions regarding participants' views on body modification were asked and we identified that participants did not perceive tattoos and piercings to be a form of self-harm. This view was held by all of the participants. When P4 was asked if she considered tattoos and piercings to be forms of self-harm, her response was:

“...in my opinion it's not for the same reasons, I've got tattoos but I wouldnae cut myself.....no I think it's completely and totally different, it's to express...your individuality and your own taste...I think it's totally separate.”

These views support McAllister's (2003) suggestion that in cultures where tattoos and piercings are the norm, they should not be considered pathological. Similarly, P5 claimed that body modification is not self-harm because “it's an expression”. However, destructive self-harm is also often conceptualised as expressive, though it may be an attempt to express psychological distress (Sutton, 2007) rather than individuality. This dichotomy in the minds of our participants may again reflect media effects on perceptions of social norms. People in society are regularly exposed to individuals, including celebrities in the media, who have numerous tattoos all over their bodies and these are usually deliberately and prominently displayed. P6 alluded to this when he said that a tattoo is; “something that you're happy to show off to folk...” On the other hand, when more common self-harming behaviours are portrayed in the media, they are often accompanied by negative words such as ‘sick’ and ‘grotty’ (Smart, 2007).

Another interesting finding of the study was that participants often seemed to make distinctions between *Personal attitudes* and *Societal attitudes*. The *Personal attitudes* displayed by nearly all of the participants in this study were sympathetic towards individuals who self-harm. One of the interview questions

was 'How do you feel about people who self-harm?'. The general response to this question was either "I feel sorry for them" (P3) or "I think it's a shame for them" (P6). However, the response of P2 was:

"...I've got divided opinions, I've got sympathy in a sense if they've had, a terrible upbringing...but at the same time I still think they're idiots for wanting to actually harm yourself...in my own opinion, I think it's a bit, bit pathetic really."

Nevertheless, with the exception of P2, these personal attitudes displayed by the general public contrast somewhat with the personal attitudes displayed by some health care professionals in previous studies. For example, According to Law et al, (2009), health care professionals' perceptions of people who self-harm are often negative and unsympathetic. However, health care professionals see self-harming patients on a regular basis and they may become frustrated when there are other patients in A&E who have suffered serious injuries by accident (Harris, 2000). Our findings suggest that the sometimes negative perceptions of health care professionals may be a result of the work related pressures they face rather than reflecting general attitudes of the lay public (e.g. Duperouzel & Fish, 2007).

Participants were also asked 'What do you think is societies view of people who self-harm?' and responses indicated that six out of 7 participants believed that people who self-harm are perceived negatively in society. P5 believed that individuals who self-harm are viewed as "nut jobs" by people in society and the response of P6 was :

"I think it's not looked at as serious as it should be...especially if they're young they're just seen, especially in today's society with all the vampires and Goths and stuff, they're just seen as moody teenagers and they'll grow out of it."

These findings support previous research conducted by Oldershaw et al, (2008) on parents' perspectives of their own child's self-harm. Oldershaw et al, (2008) found that parents' viewed their child's self-harm as a 'phase' or as an indication

that they were conforming to a 'fashion'. In addition to this, it was also found that parents perceived their child's self-harming behaviours as their own choice.

However, despite the fact that most of the participants in our study assumed that people who self-harm are perceived negatively in society, they all reported sympathetic personal attitudes towards such individuals. Considering the dichotomy between participants' responses and the negative perceptions discovered by Law et al (2009), previously discussed, it is possible that participants in the present study were affected by concerns surrounding the perceived social desirability of their responses. In particular, they may have made assumptions about the attitudes of the interviewer and been concerned with being viewed positively. Future studies employing anonymous surveys examining participants' attitudes to self-harm would help to evaluate this possibility.

Another area of interest in this study was whether or not participants associated self-harm with mental illness and how much responsibility participants placed on an individual who self-harms. Following research by Hadfield et al, (2009) which suggested that A&E doctors may perceive people who self-harm who have been diagnosed as suffering from a psychiatric disorder as less responsible and thus more deserving of treatment, we examined whether such perceptions extended to the participants in our sample.

Five out of 7 participants believed that individuals are responsible for their own self-harming behaviours. However, P3 said that as he was not sure how responsible people are for their self-harm, he did not feel comfortable answering that question. P2 on the other hand maintained that:

"...it's their own fault really, it's their own responsibility for doing it, its not as if, other people are telling them to do it..."

Interestingly, P1 believed that although people are responsible for their self-harm, people are more responsible for their anorexic behaviours than they are for more stereotypical acts of self-harm such as cutting. When asked about anorexia she said:

“It’s not someone else that’s doing it to you and it is harming your body, I know it’s like a different form, it’s not like cutting like people just expect...it’s something that’s actually about you, you know...you’re doing it to yourself”.

Although this opinion was only expressed by one participant out of the 7, it is of interest in relation to previous research suggesting that anorexia is generally perceived by the public as an illness (Sansone & Levitt, 2002). However, P4’s interpretation of anorexia supports such research and conflicts with P1s belief. This is evident when she says:

“...if it’s obvious, if it’s leaving scars and it’s showing, I think then it’s about control and wanting to feel the pain...but I think if you’re starving yourself, you know you’re harming yourself but you cannae help it...”

This finding, that 5 out of 7 participants believe that individuals are responsible for their own self-harming behaviours is quite an intriguing finding considering how much sympathy was expressed by the majority of participants towards people who self-harm. It may be that sympathy for those who self-harm does not depend on perceptions of control, and this could have implications for understanding sometimes negative perceptions in health professionals, and how to address them.

Participants’ opinions on the issue of self-harm as a mental illness were divided, 3 of the 7 participants did not think of self-harm as a mental illness. For example, P2 said:

“...majority of the time I’d say it was probably more...peer pressure than it was mental illness...”

However, the other 4 participants believed that a person must have something mentally wrong with them in order to carry out an act of self-harm. P5 believed that even if the self-harming act is carried out to gain attention then there is still

a psychological issue present as there are other, less harmful ways to gain attention; his response was:

“I think if it’s, if they’re seeking attention through self-harming I don’t think it’s a mental illness but then again...it’s a double edged sword, if they’re, they’re self-harming for attention...it’s gotta be something mentally wrong with somebody to do it aye.”

One explanation for these findings is that since the participants interviewed were members of the general public, their knowledge and understanding of psychiatric disorders may have been limited or even incorrect. This means that their perceptions of the mental health of people who self-harm may have been influenced by this incorrect or limited knowledge. This seems to be apparent in the interview of P4 as she said “...it is a kinda psychiatric disorder isn’t it if they’re self-harming”. However, her response to the very next question ‘Do you personally believe that self-harm is the result of a mental illness?’ was:

“I don’t think it’s a mental illness I think it’s a...kinda, incapable of dealing with stuff normally so this is the way they deal with it, I think it’s...definitely an emotional issue.”

This suggests a distinction in the mind of this participant between psychiatric disorder and mental illness and some degree of indecision as to whether self-harm constitutes either of these.

It was also found that 3 out of 7 participants believed that their attitudes towards those who self-harm would be altered if the individual was diagnosed with a psychiatric disorder. For example, P2’s initial attitude was: “...they’re idiots for wanting to actually harm yourself...”. However, when asked if he would feel different upon the diagnoses of a psychiatric illness, P2 responded:

“Yeah possibly...if you are mentally ill then fair enough you do, you do need help with things like that...I’d rather they would get help, possibly more than the other people...”

Despite this, the other 4 participants said that their sympathetic attitudes would not change. P7 said that she would still feel sympathy for a person who self-harmed if they had been diagnosed with a psychiatric disorder “ ‘coz it’s not really their fault”. This perception of self-harming individuals who have been diagnosed with a psychiatric disorder was also held by the health care professionals in Hadfield et al’s, (2009) study. The A&E doctors in this study also believed that a patient who self-harms is not responsible for their acts of self-harm if they are suffering from a psychiatric illness. Interestingly, rather than this psychiatric label creating a negative attitude towards those who self-harm as was proposed by Johnstone, (1997) it may be the case that this labelling contributes to a more sympathetic attitude in both health professionals and the general public. For instance, P6 said “...if they’ve been diagnosed with some mental disorder...it disnae mean that, it’s any less...traumatic for them.”

A number of the interview questions were aimed at identifying participants’ understandings of what motivates acts of self-harm. These included; ‘What do you think people are trying to achieve by self-harming’ and ‘Do you think that specific methods of self-harm are motivated by specific factors?’ As expected, there were a number of different motivations that participants identified as the causes of self-harm. These included depression, guilt, peer pressure, trauma, a cry for help, release, attention-seeking, fear, control, bullying and loneliness. However, our analysis suggested that the four that appeared to be the most prevalent in the data were; *Depression, Guilt, Release* and *Bullying*.

Four of the 7 participants believed that *depression* is a major factor in relation to self-harm. P2’s understanding of the term self-harm was:

“...basically somebody who seems depressed and there’s something wrong within their life...so they decide oh I’ll take it out on myself”.

Additionally, P6 made an interesting judgement when he said: “...I reckon that...self-harm comes from, in at least some way depression, whether it be mild or major depression. I reckon it...it all stems fae...that”.

This reflects previous findings by Skegg (2005) which suggest that 90% of individuals who self-harm who were presented to hospital had a psychiatric disorder, the most common of which was depression. Laye-Gindhu and Schonert-Reichl's (2005) study, discussed previously, also found that depressive disorders were strongly associated with deliberate self-harm. The fact that 4 participants in this study identified depression as a major factor in self-harm is interesting because it suggests that at least some members of the general public have a basic understanding of the issues that may motivate a person to self-harm.

Another factor that was identified as a motivation for self-harm was *guilt*. Three of the 7 participants believed that self-harming behaviour may be spurred on by feelings of guilt. When P5 was asked what he thought people were trying to achieve by self-harming his response was "either to get attention or to alleviate their selves of some kind of guilt...". Also, P7 believed that the definition of self-harm is "someone who hurts their self because they're trying to hide something". There are many studies that have been conducted into the motivations behind self-harm, however, nothing has been found that suggests that guilt is one of these motivations. The fact that some people in society believe that guilt could be a motivating factor is an interesting finding since it may place the emphasis on the individual who self-harms by implying that the person has something to feel guilty about.

The next significant motivation that was identified in this study was *Release*. Four of the 7 participants identified release as a motivating factor for self-harm. P3 believed that "...the self-harm is a release from the tensions..." and P6 believed that people use self-harm as an attempt to release themselves from reality. He said that people are

"...trying to forget about what they're, what they're thinking about and what they're feeling like by concentrating on another type of pain or another type of suffering".

These findings reflect Harris' (2000) study given that she found that women who self-harm often explain that their self-harm, particularly in the form of cutting, serves as a release from the pressure they are experiencing and allows them to release all of their built up negative emotions.

The last significant motivation we identified was *Bullying*. P6 believed that people who get bullied are more likely to self-harm as he said:

“...people who get bullied they're...they're more likely to do it...some folk would take it too seriously and start to get a complex about themselves. Bullying's a big form of it I think”.

This accords with previous findings suggesting that bullying may be a motivating factor in self-harm. For example, Fortune et al, (2008) found that 6% of the adolescents in their study believed that bullying had negative effects on people who self-harm and that bullying should be more effectively dealt with in schools to prevent acts of self-harm being carried out. However, it is unclear whether Fortune et al's (2008) participants perceived the self-harming acts to be a direct result of the person being bullied or whether the bullying stemmed from the individuals' self-harming behaviour. Regardless of this, the two participants that identified bullying as a motivational factor in our study both suggested that bullying was the cause of a person's initial self-harming behaviour.

Conclusions.

This is one of the first qualitative studies to look at public perceptions of self-harm and although limited in scope, it provides some interesting insights which could be profitably further investigated in future studies. A number of our findings accord with previous research highlighting how social norms influence perceptions of self-harm, particularly in relation to eating disorders and body modification. Given that such norms differ between social groups, it would be interesting to study perceptions of self-harm within, for example, teenage sub-cultures; previous research, together with the perceptions of at least one of our participants, suggest an association between “Goth” culture and self-harm

(Young et al, 2006). Similarly, given that previous research has suggested that self-harm may be more prevalent in certain ethnic groups (e.g. Cooper et al, 2010) it would be interesting to study whether this is reflected in differences in perceptions of self-harm between individuals of different ethnicities. Although the current findings should not necessarily be considered representative of the general population, due to the relatively small sample size, our findings do suggest that, in contrast to some health professionals, members of the public may be less inclined to see self-harm as attention seeking, and may also be more sympathetic towards those who self-harm. This suggests that the negative perceptions sometimes observed in health care professionals may largely result from situational factors involved in working in often stressful and demanding environments (e.g. O'Donovan and Gijbels, 2006), rather than reflecting generally negative attitudes towards individuals who self-harm. Furthermore, within our sample, it seems that unless an individual who self-harms was perceived to be suffering from a psychiatric disorder, they were generally perceived as solely responsible for their own self-harming actions. These perceptions correspond to those of health care professionals often reported in previous studies.

An additional interesting finding that emerged from this study is how the severity of self-harm appears to be measured by how publicly it is displayed. Five participants in this study perceived self-cutting to be worse than eating disorders because they perceived cuts and scars to be more difficult to hide than weight loss. These perceptions may be based, at least in part, on media influences and how the media portrays these different behaviours. Again, as this was a preliminary study, this finding cannot be generalised to the wider population and a larger study with a more representative sample would be needed to further investigate this.

Regardless of these findings, some limitations of this study should be acknowledged. As with all qualitative research, our findings are necessarily influenced by our own subjective viewpoints. However, the matrix analysis we employed here takes a systematic and rigorous approach to developing

themes, and we are confident that our analysis adequately reflects the perceptions and opinions of our participants. However, the present research, by highlighting some of the ways in which individuals think about the issue of self-harm, could profitably be used to develop quantitative surveys of public attitudes to self-harm to be administered on a much larger sample. Such survey methods would also afford participants greater anonymity which might help to counter potential issues with socially desirable responding in our study. Further research in this area may also benefit from studies to identify how self-harm is portrayed in the media and whether the media has a positive or negative influence on public perceptions of self-harm.

Despite these limitations, the current study represents an important development in our understanding of public perceptions of self-harm which could be used as a starting point to raise awareness of the phenomenon and reduce the stigma and discrimination attached to people who harm themselves.

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