Blurred boundaries: A qualitative study of how acts of 'self-harm' and 'attempted suicide' are defined by mental health practitioners.

Abstract

Background: There is no commonly accepted definition of the term 'self-harm', and an on-going debate about whether or not it should include acts of attempted suicide. The use of this language in clinical practice has not previously been explored.

Aims: To investigate if, and how, practitioners distinguish between acts of 'self-harm' and 'attempted suicide', and any implications for practice.

Method: We conducted semi-structured interviews with a random sample of 18 frontline practitioners from 10 mental health wards and completed a thematic analysis of interview data.

Results: Most participants described 'self-harm' and 'attempted suicide' as distinct behaviours, differentiated by the characteristics of self-harm, disclosures of intent, and the level of distress observed. Few believed that people who self-harm may also feel suicidal. Practitioners differentiated these behaviours confidently, yet accounts revealed challenges and complexities associated with the separation of these acts in routine practice

Conclusions: Our findings suggest there is no common understanding of the boundaries between these behaviours amongst clinicians and that the language currently used and consequent practice, particularly with regards to risk assessment, is problematic.

Limitations: Clinicians working in the community, or in less ethnically diverse areas, may have different views. Participants' accounts may not be an accurate representation of what happens in practice.

Introduction

There is no commonly accepted definition of the term 'self-harm' (Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007; Silverman & De Leo, 2016), and an on-going debate in the literature about whether or not it should include acts of attempted suicide (De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006; Muehlenkamp, 2005; O'Carroll et al., 1996). In the UK, the National Institute for Health and Care Excellence (NICE) advises against the separation of these behaviours because "*motivation is complex and does not fall neatly into such categories*" (NICE, 2011, p. 14), whilst in the US, 'Non-Suicidal Self Injury' (NSSI) and 'Suicidal behaviour' are separate disorders, included in the DSM-5 (American Psychiatric Association, 2013). Those in support of a separate diagnostic category of NSSI argue that NSSI is distinct from suicidal behaviour because it occurs in the absence of suicidal intent, and so requires different approaches for prevention and treatment (Muehlenkamp, 2005). The inclusion of NSSI in the DSM-5 has led a number of studies to investigate differences amongst people seen to be engaging in NSSI and those who have 'attempted suicide', and these studies have found some significant differences. For example, people who have attempted suicide have a more negative view of life (Muehlenkamp & Gutierrez, 2007; Whitlock & Knox, 2007), and are more likely to have experienced traumatic life events such as childhood abuse, the death of a friend of family member, and worries about their sexuality, compared to people who self-harm (Baetens, Claes, Willem, Muehlenkamp, & Bijttebier, 2011; Whitlock & Knox, 2007). Those who support a definition which includes all acts of self-harm, regardless of suicidal intent, argue that intent is not either present or absent but is a fluid concept which can exist to varying degrees and fluctuate over time (Hawton, Saunders & O'Connor, 2012; Kapur, Cooper & Hawton, 2013). For example, a study of 106 people hospitalized following an attempted suicide found that fifty percent reported a co-occurring wish to live and to die at the time of the act, and people describe experiencing self-harm, suicidality and attempted suicide as part of a complex continuum (Kovacks & Beck, 1977; Ben-Zeev, Young, & Depp, 2012; NICE, 2011, p. 52). Consistent

with these data, a recent taxometric investigation of the latent structure of suicidal and non-suicidal self-injury amongst 1,525 female undergraduates concluded that these behaviours are dimensional variations of a single construct (Orlando, Broman-Fulks, Whitlock, Curtin, & Michael, 2015).

The current debate regarding the definition of self-harm is a significant barrier to the progress of research in this field because it means that studies frequently adopt different definitions of 'self-harm' (e.g. James, Stewart & Bowers, 2012) and so cannot reliably be compared (Silverman & De Leo, 2016). Whilst most research in this area has focused on exploring differences between people who engage in 'suicidal' vs 'non suicidal' self-harm (e.g. Csorba et al., 2009), very little attention has been paid to how the terms 'self-harm' and 'attempted suicide' are used by clinicians. The use of this language may have important implications for practice, because, for example, a nurse would respond differently to an 'attempted suicide' compared to an episode of 'self-harm'. There is evidence that UK practitioners differentiate between these behaviours, with separate categories for 'self-harm and 'attempted suicide' used in official incident reports (Bowers, Dack, Gul, Thomas & James, 2011; James, Stewart, Wright & Bowers, 2012). However, to our knowledge, practitioners' understanding of these terms have not previously been explored. This study aimed to contribute to debate regarding the appropriate taxonomy for these behaviours by investigating if, and how, clinicians distinguish between acts of 'self-harm' and 'attempted suicide', and any consequent implications for practice.

Methods

This study formed part of the Safewards trial (Bowers et al, 2015) and comprised a survey of attitudes amongst inpatient mental health practitioners towards self-harm, using the Self-harm Antipathy Scale (Patterson, Whittington & Bogg, 2007; Phase I), followed by interviews with a subsample of 18 participants (Phase II). The data reported here are from Phase II. For Phase II, the sample were participants randomly selected from those within both the top (range = 111-139; n=8), and bottom (range= 36-52; n=10), 10th percentile of Self-harm

Antipathy scores collected from the control arm of the Safewards RCT during Phase I (see Bowers et al., 2015 for the Safewards inclusion criteria). Participants were 'frontline' professionals, such as mental health nurses and nursing assistants, who deliver the majority of care to people who self-harm in inpatient settings. A high antipathy score indicates a negative attitude towards self-harm. There were no systematic differences regarding the understanding or use of the terms 'attempted suicide' and 'self-harm' between groups of high and low antipathy staff. To demonstrate this, quotes from high and low scoring practitioners are denoted 'hi' and 'lo' respectively in the text.

Semi-structured interviews were conducted with 18 participants over a 9 month period at the end of the Safewards trial. Eligible practitioners were listed in a random order and the first ten from each group invited to participate. Interviews were guided by a schedule of questions which ensured that all topics of interest were covered during the interview and meant that interviews were similar in their structure and content to aid comparison between transcripts. Interviews were conducted in a meeting room on the ward or within the hospital, and were recorded using a digital voice recorder.

All interviews were transcribed verbatim and the transcripts anonymised. Interviews were analysed using thematic analysis which aimed to provide a detailed account of themes related to the research aims, rather than a representation of the entire dataset (Braun & Clarke, 2006). Thematic analysis is a method for identifying, analysing, and reporting patterns of meaning across an entire data set, rather than within a data item, such as an individual interview transcript from one person (Braun & Clarke, 2006). For this study, a 'theme' constituted a pattern of meaning which was either directly observable in the data, or seen to be underlying what was said in the data (Joffe, 2011) and data analysis followed the six stage process outlined by Braun and Clarke (2006). All interviews were repeatedly read by KJ, who developed the original coding framework, which was then further developed through an interative process involving regular meetings and discussion with DS, to ensure the themes were coherent and internally consistent.

Results

The eighteen interview participants comprised thirteen Mental Health Nurses, four Healthcare Assistants and one Occupational Therapist. The majority of practitioners were over 30 years of age (20-29: n=4; 30-39: n=6; 40-49: n=6). Most were women (n=13), most were from an African ethnic background (n=9), six were White, two were South Asian and one was Caribbean. Most (n=13) had worked in mental health for over five years, three for 3-5 years, one for 1-3 years and one less than a year.

All but one participant said they used the term 'attempted suicide' to describe a behaviour they saw as distinct from self-harm. In many accounts practitioners contrasted "*people who commit suicide*" and "*self-harmers*" and in doing so identified attempted suicide and self-harm as behaviours that would not be displayed by the same person**.** Participants used a broad range of criteria to distinguish between these behaviours which differed between individuals, including those working on the same ward. Practitioner perspectives on the differences and similarities between 'self-harm' and 'attempted suicide' were captured in the following themes:

1. **Going full force into it:** inferring suicidality from the characteristics of the act of self-harm.

2. **Disclosing intent:** inferring suicidality from what people told practitioners about their intent.

3. **A darker place:** inferring suicidality from observations about an individual's state of mind.

4. **Blurred boundaries:** where in their accounts practitioners reveal that they do not perceive a clear divide between acts of 'self-harm' and 'attempted suicide'.

Going full force into it

"*Going full force into it*" was an expression used to define the act of attempted suicide and this theme captures how practitioners used the characteristics of self-harm to distinguish between suicidal and non-suicidal behaviour. Participants believed that during an attempted suicide people did everything they could to make sure they did not survive, including using high lethality methods and taking steps to ensure they were not discovered. For many, this was the strongest indicator of suicidal intent:

> *Hi1: "I think people who end up doing, committing suicide, like, they're not really, they don't go through this long period of self-harm, self-harming, they just kill themselves"*

Participants used the method of self-harm as an indicator of suicidal intent, and for some this was related to the perceived level of risk to life, e.g., a large overdose of medication was considered to be a suicide attempt, whilst a smaller number of pills, self-harm. Other practitioners made judgements solely based on the type of method used, for example all acts involving a ligature were classified as a suicide attempt, regardless of lethality:

> *Hi2: "Ligature, for example, any ligature is attempted suicide. I'm not saying it's self-harm; it's attempted suicide…I would definitely draw the line."*

> *Hi4: "Yes, I think that's the difference, to be honest, the extreme. There's superficial, up here [shoulder], and then there's here and here [wrist]"*

Some participants also took into account indicators of the likelihood that a person would be found, such as the time and place of the incident. Cases where a person was thought to have taken action to ensure they were not discovered were described as an attempted suicide. Correspondingly, a person who engaged in a visible act of self-harm was often not believed to be suicidal. This could be the case regardless of the severity of the episode of self-harm:

Hi7: "Then she will go to the bridge and she will walk in front of the camera until the police notice her…you know she didn't want to jump. She held them [her hands], it took the police and the fire brigade a lot of time to come in, so because her hands got tired she couldn't hold them anymore and that was why she fell."

For some, an individual's understanding of lethality was also important, i.e. whether they knew the act could end their life. For example, some believed people could mistakenly put their life at risk without intending to die, whilst one participant felt that those using less severe methods of self-harm could also be suicidal:

Lo5: "They may think, 'I'm just self-harming"…and cuts a vein. Which may be so severe that if they don't get immediate help, it could lead to death. But it wasn't done, or it wasn't meant for them to actually engage in any suicidal activity".

Lo8: "We're not, we're not all supercharged to be doers. There's always a protective element, pain is one. Pain is one, so like it can be superficial"

Disclosing intent

This theme describes participants' accounts of how suicidal intent can be determined on the basis of what people disclosed to practitioners about their suicidal thoughts and feelings. A number of participants characterised people who are suicidal as being quiet and hiding their feelings from practitioners. Paradoxically, this meant that those who actually expressed suicidal thoughts were not considered to be suicidal:

Lo10: "Most of the self-harmers ask for help. They will go to a bridge and call for help…Whereas suicidal patients, they will normally behave quiet, they don't talk much, they make their plan and they make it."

Lo5: "Most people who commit suicide, it's, they do it in a clandestine way…But people who, maybe, who come to the hospital, to the general hospital, and say 'oh I'm having these thoughts of suicide', it means they are not actually going to do it"

Others, however, took the opposing view and said they "*always go on the client's word"* so would only use the term 'attempted suicide' to describe a behaviour if the person had told them they were suicidal. One participant described how people who regularly self-harm sometimes tried to tell her they were at risk of engaging in a life-threating act of self-harm, without describing themselves as suicidal:

> *Lo3: "Sometimes, if they regularly self-harm, they'll come and say, "I'm not feeling very safe today." That, to me, is an indicator that it's not a normal day… sometimes, when they come to me and say that, I think they want me to help them to avoid it, because part of them doesn't want to, because they know it's not going to be safe"*

A darker place

This theme outlines the ways in which participants used their observations of the level of distress experienced by the individual to determine whether or not they were suicidal. In these accounts, people who attempted suicide were described as being in "*a darker place*" to those who self-harm:

> *Lo5: "[attempted suicide] it's different from self-harming. With suicide it's someone who is very distressed and has expressed thoughts to kill himself and is subjectively and objectively very depressed and has given up on life"*

People who were suicidal were described as having "*real problems*" and being "*just down*" all of the time. Contrastingly, those who self-harmed were described as being happy at least some of the time. These characterisations further reinforced the differences between 'people' who are suicidal and 'people' who self-harm. For example:

> *Hi1: because I think that they [people who attempt suicide] don't really want to or really don't know how to release their, their sad emotions, so that's what I think brings them to do something like that, whereas someone who self-harms they, they are releasing all the time"*

Some practitioners, however, gave examples of where this approach could be unreliable, such as people who had appeared cheerful but had taken their own life, or who were initially depressed, but whose mood lifted before they died by suicide.

Blurred boundaries

This theme outlines contradictions or confusion in practitioners' accounts which indicate that, despite describing self-harm and attempted suicide as two distinct behaviours, they did not see a clear divide between these acts. One participant explained that although these acts are different she did not view them as completely distinct:

> Hi5: *"If it's suicide, suicide is different from self-harming. But altogether it's still self-harming if you can kill yourself, commit suicide, you're one way or the other, harm yourself, so I don't know. It's something a bit different, but they're all the same umbrella. One umbrella."*

Here Hi5 describes self-harm and attempted suicide as two different forms of the same type of behaviour; both involve causing harm to one's self, and so "*altogether it's still self-harming*". Almost all practitioners gave confident accounts of how these behaviours could be differentiated using a range of criteria, as described above, yet several reported cases where they struggled to determine suicidal intent:

> Lo3: *"It was unclear whether that was an actual suicide attempt, or whether it was an expression of her pain and unhappiness."*

> Lo9: *"Strange isn't it? Nobody was really sure that it was self-harming. Is this self-harm? Is she really feeling suicidal? Everybody was confused."*

There were contradictions in participants' accounts which reveal the complexities associated with the use of this language and suggest it may be unreliable and inconsistently applied in practice. Here Hi2 initially gives a very definitive account of how, during an attempted suicide, a "*quantity*" of pills would be taken, yet later contradicts this position:

Hi2: *"It's very clear; based on what the patient would be doing. Let's say, depending on the quantity of the overdosing…So if it was just a few, the person, we'll say, is self-harming; it wasn't attempted - but if it was a quantity, then that was attempting suicide. That was really an intention to kill themselves"*

Hi2: *"That could be something circumstantial, like they didn't have enough [pills] to kill themselves".*

In the same manner, Hi8 starts by saying acts of attempted suicide are by ligature only, but later reveals that "*cutting certain places*" could also be considered a suicide attempt:

Hi8: *"We would only ever say 'attempted suicide' if the individual tries to ligature"*

Hi8: *"There is a risk to life generally with self-harm, but it's just when it escalates to, maybe, ligatures and cutting certain places that you know will actually end your life."*

Here, Hi8 describes attempted suicide as an escalation of self-harm. In many interviews practitioners maintained that attempted suicide and self-harm are distinct, yet also used language which suggested these acts are part of a continuum of behaviours. For example:

Hi4: *"I think they are very different. I think that self-harm is a form of release.*

Hi4: *"I think it always goes on levels. I see it as levels… she had self-harmed over the years. It increased to ligaturing, and I think that was a serious attempt."*

One practitioner believed that suicidal intent could fluctuate over time, giving a detailed account of a recent case where someone moved into and out of a suicidal state of mind during a single incident:

Lo3: "*I've recently had a client - actually, the patient is still on the ward - who does have a history of self-harm, but sometimes the self-harm is more of a suicide attempt, and not entirely just self-harm…[description of incident]. I said to her, "I'm glad I was hot on your tail." She goes, "I'm really glad you were hot on my tail as well." So she*

knew that she'd got out of control…and if I hadn't been, she probably would have died…That sort of unleashed abandonment; fleeting, it's just so risky, because people very easily cause themselves serious harm in that split second, where all emotions and everything's loose, and nothing's in control".

Another described how the individual themselves may not be clear as to what their intent is, and be simultaneously suicidal yet also uncertain that they want to die at the time of the act:

Lo2: It might be that they're in two minds – will I actually kill myself or will I just go far enough that actually I'm harming myself seriously but not killing myself? That's where it's hard to make that distinguishing difference"

A number of participants described the challenges associated with the use of this language, which requires staff to label an act which was seen as a very "*personal"* experience. Some had particular concerns about the use of the term 'attempted suicide', because it had implications which could be problematic for both service users and the nursing team. For example, if mistakenly used this term could lead to people feeling misunderstood:

Lo6: "I've never really heard anybody say they've attempted suicide…I think again that's a very personal thing, and what one person may interpret it as "you tried to commit suicide" and one, another person's completely different…They [the service user] may feel terrible that somebody may think, 'oh they think I'm trying to end my life, but I'm just trying to harm myself."

Or because this language will influence the perception of risk and consequent decisions about clinical care:

Lo7: "if you document someone has made a suicide attempt in their risk assessment, you're branding them for the future. You're giving them a name, "She has tried to take her life". In the future, people become very scared. Services, I think, become

very over protective and that's when there comes all this massive chaos around people"

Here Lo7 describes how the term can provoke a strong reaction from staff and uses the word "*branding*" to indicate how documenting a behaviour as an attempted suicide can have a very permanent impact on how a person is viewed in the future. Lo7 later gives an example of how an incident could be described without using this language, in a more informative way that outlines the context and features of the act:

Lo7: "I think sometimes they worded it that "she attempted to strangle herself in an attempt to take her life." When really, I think it could have been worded differently: "She had just attended ward round and been told of her impending discharge. She was upset, and went back to her room and she was found with tights around her neck"

Discussion

We aimed to contribute to the debate regarding the appropriate taxonomy for self-harm behaviours by investigating if, and how, clinicians distinguish between acts of 'self-harm' and 'attempted suicide'. To our knowledge, this was the first study to explore the use of this language in clinical practice. We found that rather than the definition of 'self-harm' outlined in UK guidance, i.e. "*any act of self-poisoning or self-injury carried out by an individual irrespective of motivation*" (NICE, 2011, p14), UK practitioners adopted the US approach where 'self-harm' was used to refer to acts without suicidal intent, seen as distinct from an 'attempted suicide'. Criteria used to determine intent varied between individuals, including those working on the same ward. These included the characteristics of self-harm, what people disclosed to practitioners about their intent, and practitioner's observations about the individual's level of distress. Participants gave confident descriptions of how they could differentiate these behaviours based on these criteria, yet contradictions in accounts suggested this was more complex and challenging than they claimed.

People who self-harm describe suicidal intent as fluid concept, which is not either present or absent, but can exist to varying degrees and can be experienced alongside a desire to live (Kovacks & Beck, 1977; Ben-Zeev et al, 2012; NICE, 2011, p. 52). Whilst there is some evidence of differences between groups of people engaging in 'suicidal' and 'non-suicidal' self-harm (Baetens et al, 2011; Whitlock & Knox, 2007), findings from recent research suggest that, rather than being 'distinguishing' characteristics (i.e. which are present in one group and absent in another), these are characteristics which exist to a greater degree in one group compared to the other, indicating a continuous spectrum of behaviours rather than two distinct categories (Orlando et al., 2015). In line with these data our findings indicate that there are challenges and complexities associated with the separation of these acts in routine clinical practice and that the criteria practitioners use to distinguish between these behaviours are inconsistent. Whilst the DSM-5 diagnostic criteria for Non Suicidal Self Injury (NSSI) may encourage a more systematic approach, its application is likely to be problematic because it is very difficult to determine intent based on observable criteria. For example, participants described cases where intent was unclear, where intent may have changed during a single incident, or where a person used low lethality methods of self-ham but was experiencing suicidal feelings.

Our findings also suggest that the dichotomous separation of these behaviours leads practitioners to overlook the strong association between self-harm and suicide. In this study very few participants acknowledged that people who self-harm may also feel suicidal, and many characterised these behaviours as occurring in different 'types' of people. In a number of accounts participants prioritised observable 'indicators' of intent such as the characteristics of the act of self-harm over what people disclosed to them about their experiences, meaning that when someone who self-harmed expressed suicidal feelings they were not taken seriously, even following a high-lethality episode of self-harm. This is concerning as a history of self-harm is the strongest predictor of suicide, over and above all other psychosocial characteristics (Sakinofsky, 2000), such that between 40-60% of people

who take their own life have previously self-harmed (Hawton & Fagg, 1988; Rygnestad, 1988; Suokas & Lönnqvist, 1991)

Evidence that the separation of these behaviours is unreliable has other important implications for practice because this language communicates an assessment of the motivations underlying these behaviours, and more importantly, level of risk. Participants described how the term 'attempted suicide' can provoke a strong reaction from practitioners and have a lasting impact on how a person is treated in the future. If used incorrectly this could lead to someone feeling misunderstood and so have a negative impact on relationships with practitioners, or their recovery. It could also mean they have a longer inpatient admission, or are subject to unnecessarily high levels of containment such as constant observation and restricted leave (Drew, 2001; Foster, Bowers & Nijman, 2007; Low, Terry, Duggan, Macleod & Power, 1997).

Conclusions and recommendations

By highlighting the complexities involved in determining intent, the impact of the term 'attempted suicide' on perceptions of risk, and the consequent implications for practice, findings from this study add to a body of evidence which argues against the dichotomous separation of these behaviours into acts of 'suicidal' and 'non-suicidal' self-harm (Kapur et al., 2013; Orlando et al., 2015; Silverman & De Leo, 2016). We recommend that practitioners are discouraged from using the term 'attempted suicide'. One suggestion for a more accurate conceptualization of the severity of self-harm is the use of 'severity specifiers', e.g. descriptions of self-harm as mild, moderate or severe (Orlando et al, 2015). We suggest any assessment of severity should consider the circumstances and features of the act, for example a lethality rating or a description of lethality (e.g. an indication of how tight the ligature was, if it was tied, if it was attached to anything), the circumstances of the act (e.g. was the person likely to be found?), and an account of what the person said about what they were experiencing at the time, including any suicidal thoughts and/or feelings.

When supporting a person who self-harms risk assessment should be a continuous process, carried out by frontline professionals, such as mental health nurses and healthcare assistants, who provide 24-hour care to people who self-harm on mental health wards and so are best placed to make judgements about risk, alongside the service user themselves; Practitioners should be encouraged not only to consider observable indicators of risk, such as the features of the act of self-harm, but have ongoing conversation with people about their safety and explore any suicidal thoughts and feelings. Practitioners should also be aware that people may try and tell them about risk in different ways, for example by referring to 'feeling unsafe' or having a 'bad day', so that they do not overlook times when a person may be at risk of high lethality self-harm.

Finally, practitioner training should focus on the relationship between self-harm and suicide. Training should highlight the prevalence of suicide amongst people who self-harm compared to the general population, should include explanatory models for the relationship between these behaviours (e.g. Joiner, 2005) and personal accounts of people's experiences of self-harm and suicidal thoughts and feelings.

Limitations

This was an exploratory qualitative study; we did not seek to identify experiences amongst a 'representative' sample of clinicians, and so these issues may not be encountered within all mental health services. This study was only conducted with frontline professionals in inpatient mental health services (i.e. mental health nurses and nursing assistants), and so clinicians working in the community, or those from other disciplines, such as psychiatry, psychology or social work, may have different views. In addition, the study was conducted with an ethnically diverse group of staff in the South East of England, and staff in other, less diverse, areas may hold different views. Finally, the data for this study were drawn from participants' accounts of how they used this language which may not be an accurate representation of what actually happens in practice.

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