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Citation for published version:
Chandler, A, King, C, Burton, CD & Platt, S 2020, 'The social life of self-harm in general practice', *Social Theory & Health*, vol. 18, no. 3, pp. 240-256. https://doi.org/10.1057/s41285-020-00139-9

Digital Object Identifier (DOI):
10.1057/s41285-020-00139-9

Link:
Link to publication record in Edinburgh Research Explorer

Document Version:
Peer reviewed version

Published In:
Social Theory & Health

Publisher Rights Statement:
This is a post-peer-review, pre-copyedit version of an article published in Social Theory & Health. The final authenticated version is available online at: https://link.springer.com/article/10.1057%2Fs41285-020-00139-9

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Download date: 24. Sep. 2023

Accepted for publication in Social Theory and Health, March 2020

The social life of self-harm in general practice

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Abstract

Research engaging qualitatively with clinical practitioners' understanding of, and response to, self-harm has been limited. Self-harm offers a particularly compelling case through which to examine the enduring challenges faced by practitioners in treating patients whose presenting symptoms are not clearly biomedical in nature. In this paper, we present an analysis of 30 General Practitioners' (GPs') accounts of treating patients who had self-harmed. Our analysis demonstrates the complex ways in which GPs seek to make sense of self-harm. Illustrated through three common 'types' of patients (the 'good girl', the 'problem patient' and the 'out of the blue'), we show how GPs grapple with ideas of 'social' and 'psychological' causes of self-harm. We argue that these tensions emerge in different ways according to the social identities of patients, with accounts shaped by local contexts, including access to specialist services, as well as by cultural understandings regarding the legitimacy of self-harming behaviour. We suggest that studying the social life of self-harm in general practice extends a sociological analysis of self-harm more widely, as well as contributing to sociological theorisation on the doctor-patient relationship.

Key words: self-harm, general practice, primary care, doctor-patient relationship, qualitative

Introduction

When considering the 'social life of self-harm' (Steggals et al., 2019), it is impossible to avoid also engaging with the 'clinical life of self-harm'. Elsewhere, Chandler has argued that even where self-harm is enacted entirely away from the 'clinical gaze', how it is understood, accounted for and experienced may be inflected by medical ways of knowing (Chandler, 2016). Similarly, when considering the clinical life of self-harm, it is impossible to avoid engaging with the social. In this paper, we present an analysis of General Practitioners' (GPs') accounts of treating patients who had self-harmed, demonstrating the complex ways in which 'the social' is entangled with 'the clinical'. Indeed, while some analyses of health frame biomedical and social understandings as separate, perhaps oppositional, authors writing from several positions have established that (bio)medicine

itself is social, even as much of the 'power' of biomedical models comes from a pretence that 'biology' can be understood in separation from social worlds (Bendelow & Williams, 1995; Pickersgill et al., 2013; Rose, 2001; Stepnisky, 2007).

The case of self-harm in the context of general practice is particularly challenging to a biomedical model of health, and to a view of biomedicine and social life as separate. Self-harm shares with other practices, such as alcohol or drug use, and medically unexplained symptoms, an ambiguous position in medicine (Haldar et al., 2015). Indeed, a classic paper by Jeffery (1979) showed how emergency department doctors categorised a range of patients as 'normal rubbish', cases that were framed as largely social in origin and, as such, uninteresting – even irritating – to clinical practice. Patients assigned to this category included those who had self-harmed and those who were intoxicated.

In addition to being seen as presentations with social rather than biomedical causes, moral judgements were shown to be central. Indeed, sociologists have argued strongly that cases such as alcohol use are challenging to medicine in part because they involve patients who are seen as not fulfilling (or even attempting to fulfil) reasonable expectations – e.g. to look after their own health (Conrad & Schneider, 1992; Rapley et al., 2006). Following Jeffery, we suggest that those who self-harm are also viewed unfavourably in part because of assumed moral culpability. Jeffrey argued that doctors' categorisation of patients as 'rubbish' could be related to judgements about a given patient's ability to have 'acted otherwise'. Drawing on McHugh's (1970) theories of deviance and social action, Jeffrey showed that patients who could not be directly 'blamed' for the situation that brought them to the emergency department were more likely to be viewed sympathetically, even where causes were deemed social in nature. In contrast, those who were deemed as having some control over their actions were viewed with, at best, irritation.

A 'biopsychosocial' model of health is often advocated as entirely necessary and appropriate within primary care. However, significant questions continue to be raised about the 'reality' of this approach in either GP training or practice (Dowrick et al., 1996; England et al., 2017). This catch-all term has been critiqued for continuing to privilege the 'bio' and relegate the 'social' (Pilgrim & Rogers, 2005). Our analysis provides further evidence for the limitations of a 'biopsychosocial' model, showing the more embedded ways in which social relationships, identities and cultural meanings shape the way that GPs account for and understand patients who self-harm. Building on a previous paper, we suggest that GPs' interpretive orientations towards self-harm are shaped not only by the contexts in which they work (Chandler et al., 2016), but also by culturally available narratives which seek to make sense of self-harm. These available narratives are, we show, strongly

shaped by the gender and age of patients. Self-harm can mean different things to GPs – and to patients. However, to date there has been limited exploration of the way in which diverse interpretations of self-harm might impact on the doctor-patient relationship, on treatment decisions and, relatedly, on outcomes for individuals who have self-harmed and are seen in primary care.

Self-harm in general practice

Self-harm is a contested term and, particularly when considering clinical practice, definitions can be challenging (Chandler et al., 2011). In the UK, the NICE guidelines define self-harm as 'self-injury or self-poisoning, irrespective of the apparent purpose of the act' (NICE, 2011). However, as we have previously argued, the practices of injuring or poisoning the body are potentially hugely diverse, and the relationship between these different practices and risk of later suicide is unclear and complex (Chandler, 2016; Chandler et al., 2016). While there may be good epidemiological arguments for conflating self-injury and self-poisoning in some cases, when it comes to clinical care there are important reasons against. Most obviously, these practices can require different treatment (e.g. suturing and wound care for self-injury, compared to use of activated charcoal for an overdose of analgesics). Further, the 'lived experience' of these practices is also diverse, entailing different bodily practices and often different accounts of motivation and experience, though there can be overlaps. Self-injury in the form of cutting is more often associated with accounts of emotion management, visual expression of pain (to self or others), with accounts highlighting bodily effects (blood, pain, and caring for wounds) as central. Such bodily elements are not present in the same way with overdoses, and for some the two practices have very different meanings (Chandler 2016). However, existing research engaging with self-harm in general practice has tended not to trouble the definitions being used; it is therefore unclear what types of practices, and with what meanings, are being addressed (Carr et al., 2016; Michail & Tait, 2016). Understanding of the diverse motivations, experiences and clinical profiles of individuals who may self-harm in very different ways remains reasonably limited.

A significant proportion of research on self-harm in clinical contexts in the UK focuses on Accident and Emergency (A&E) settings, where the majority (around 80%) of recorded presentations or admissions for self-harm involve self-poisoning (primarily overdoses of prescribed medication) (Geulayov et al., 2016; Redley, 2010). However, in community studies (often on young people at school or university) the most common method of self-harm (around 60-70%) reported is self-cutting (Kidger et al., 2012; O'Connor et al., 2009), and the majority of (young) people who report self-harm do not report attending A&E as a result (Hawton et al., 2002). Indeed, in the 'popular imagination' (outside of NICE guidelines and clinical measurements), 'self-harm' is often taken to mean 'self-cutting' alone (Chandler, 2018; Millard, 2013; Scourfield et al., 2011).

The picture in primary care is less clear, and research in this particular clinical context has been limited. Existing studies have, for instance, followed up patients who are discharged back to their GP following presentation at hospital, so focusing on a similar population to that captured in A&E based studies – primarily including cases of self-poisoning (Bennewith et al., 2002), and not generating any data about patients (who may well be the majority) who are seen in General Practice, but who do not present in emergency settings initially. More recent research has sought to study the prevalence of self-harm presentations in primary care by analysing routinely collected information from the Clinical Practice Research Datalink. Intriguingly, the study found that 82% of recorded episodes of self-harm in the practices included in the sample were cases of self-poisoning (Carr et al., 2016). This is surprising, given what we know about community rates of self-harm tending more towards self-injuries. It is possible that the finding reflects the greater ability of patients who self-cut or burn to practice self-care; however, it is also possible that this is reflective of how self-harm is being measured and recorded within primary care. Perhaps more 'serious' incidents (especially if treated in hospital and therefore more likely to be overdoses) are more routinely formally recorded. Since the authors of the study were unable to examine related doctors' notes, it is difficult to say either way.

Whether and how self-harm is recorded in primary care notes will relate to how GPs themselves understand and define self-harm, and how they respond to different types of presentation. Reflecting the general paucity of work in this area, we know very little about this. Studies tend to take for granted that GPs know what 'self-harm' is, use the very broad NICE guidelines definition (above) or else focus exclusively on 'suicide risk' (which may include self-harm) (Michail et al., 2017). However, our own qualitative research with GPs suggests that there is significant variation in GPs' understanding of, and response to, self-harm, including their assessment of suicide risk among patients who self-harm (Chandler et al., 2016). This is an arena where GPs are obliged to make judgements and interpretations within the very broad guidelines available, if guidelines are indeed consulted, understood and followed. In-depth qualitative exploration of this issue is lacking.

Primary care research and the doctor-patient relationship

The relationship between GP and patient, and the specific interaction of the primary care consultation, has been much discussed within sociological and primary care research (Heritage & Maynard, 2006). Comparing several studies, May et al (2004) demonstrated the complex range of relational factors which appeared to influence GP accounts of patient-doctor relationships, and their views of factors which shaped longer-term outcomes. The focus in May et al's study was chronic illness, but there are important similarities between self-harm and chronic illness, notably: concerns about legitimacy of symptoms, challenges of 'successfully treating'; and the potentially 'relapsing-

recurring' nature of some forms of self-harm (Chandler, 2014). May and colleagues' comparative approach highlighted important ways in which GP accounts of doctor-patient relationships were constructed across different contexts. One common feature affecting this was whether GPs were able to offer suitable treatment options. Medical sociology has frequently shown that doctors find apparently 'untreatable' patients or conditions problematic (Blaxter, 1978). Haldar et al. (2015)'s work on doctors' accounts of prestige in relation to different conditions reflects this: "The ideal is to work with things where the patient comes in sick and leaves healthy …" (p. 569). Similarly, Jeffery suggested that A&E staff found patients particularly challenging where no 'illness' could be easily ascribed, and the presence of illness was often defined on the basis of the availability of appropriate therapy – "it would seem that this uncertainty fostered frustration which was vented as hostility towards these patients" (1979, p. 100). As discussed above, with alcohol dependence, some illicit drug use and self-harm, the picture is further complicated by concerns about the patient's agency in 'acting otherwise', and therefore their (moral) culpability for their condition

Methods

Approach

The study was designed to explore the ways in which GPs talked about treating patients who had self-harmed. We were interested in examining how GPs understood self-harm, how they talked about treating (or not) patients who had self-harmed, and how they viewed the relationship between self-harm and suicide.

Sampling and recruitment

30 GPs were recruited from two health boards in Scotland, UK. Using purposive sampling, we sought to achieve a balanced sample of GPs in terms of gender, age, years of experience as a GP, and location of the practice. Our final sample is summarised in Table 1. We used the practice postcode to indicate the level of socio-economic deprivation (using the Scottish Index of Multiple Deprivation) of the area in which the practice was located and the Scottish Government 6 fold Urban Rural Classification[1] to indicate rurality. These categorisations are only partial: they do not account for GPs moving practice during their career, or reflect practices which may serve wider, diverse areas (e.g. incorporating pockets of both affluence and deprivation, or – in rural areas – including relatively isolated communities and more densely populated towns).

[1] In Table 1, those classed as 'urban' incorporates 1-3 (large urban areas to accessible small towns) of the 6 fold classification; and those classed 'rural' incorporates 4-6, (remote small towns to remote rural). For deprivation, we used deciles, and 'more deprived' incorporates SIMD deciles 1-5, 'more affluent' refers to SIMD deciles 6-10.

Table 1

Sample Characteristic	**Number of participants**
Male	16
Female	14
Urban	21
Rural	9
More deprived area	13
More affluent area	15
Locum	2
Total sample	30

Data collection

GPs took part in a 30 minute interview, mostly by telephone, with author CK (interviews were held in 2013). Prior to the interview, GPs were asked to consider at least two recent practice examples where they had treated someone who had self-harmed ("Can you tell me about a time, recently or in the past, when you came across self-harm in a consultation with a patient?"). Thus, the first part of the interview in most cases was given over to discussing these examples. In the second, semi-structured part of the interview, GPs were asked to reflect on the meaning of self-harm, the relationship between self-harm and suicide, as well as training experience, needs and 'best practice' when treating patients who had self-harmed.

Analysis

All interviews were digitally recorded and transcribed verbatim. Transcripts were coded using NVivo 10 by author AC. Initial deductive codes were generated using the interview schedule and included: practice examples, self-harm and suicide, defining self-harm, best practice, training. This paper addresses the 'practice example' code, which was further inductively analysed in two ways: a) sub-coding based on the patient characteristics described by the GP (led by AC); b) a narrative approach, using Doucet and Mauthner's adaptation of the 'Listening Guide' to examine the ways in which GPs talked about responding to different patients who had self-harmed (led by CK) (Doucet & Mauthner, 2008). GPs' accounts were not taken as representing a window into what happened during consultations (Atkinson, 1997), but rather as a situated, contextual version of events, which could be analysed to help understand the ways in which GPs worked with patients who self-harmed, and with discursive categories such as self-harm and suicide.

Findings

Analysis of the interviews generated three dominant 'types' of patient who self-harmed, as described by GPs: the 'the good girl', the 'problem patient' and finally, the 'out of the blue'. It is important to note that these types were not neatly distinct from one another. For instance a small group of patients included in the category 'the good girl' shared similar features of those in the 'problem patient' category. A key feature of accounts placed in the latter category was framing the patient as someone who had *long-term* health problems, often a diagnosis of personality disorder.

GPs referred to 75 separate patient 'cases' in total, though each GP typically spoke in detail about just two of these. Of these 75 cases, 26 were young women (aged 29 or younger); and 49 involved self-cutting, burning or insertion of objects, with just 11 involving overdosing. The three dominant types generated by AC's analysis were characterised by methods of self-harm, as well as the gender and age of patients, and the way in which GPs related the account. In the following, we introduce these three types, showing the commonalities across GPs' accounts in terms of *how* they told stories of patients' self-harm. Our analysis demonstrates the significant ways in which cultural understandings of what self-harm is, who self-harms, and how it relates to suicide, shape GPs' accounts.

'The good girl' – the good patient who self-harms

The most common type of patient discussed by GPs was young, (mostly) female and had cut themselves (often over a considerable time period) (n=28). While there was variation within the type, GPs tended to describe these cases as involving 'good patients' who, despite having harmed themselves (and thus to some extent breaking expectations of the patient role), were nonetheless framed as being broadly committed to 'getting well'.

"the main bit was knowing that she wanted to get support and to try and stop what she was doing" **GP9**

A smaller subset was described as reluctant, even resistant, to GPs' attempts to work with them; in a few cases, these patients' self-harm was explicitly described as 'manipulative'. We surmise that some of these patients may have been younger versions of those we categorised as 'problem patients'. While almost all of these cases (26/28) involved young women, often referred to as 'the girl' (whether in mid-teens or late twenties), two young men were also included in this category as they shared all of the other characteristics.

The way in which GPs spoke about this type of patient had several recurring features. GPs often told the story of these patients in the manner of a detective story. Self-harm was seen as an indication

that something was wrong in the patient's life, abuse was often explicitly raised as a possible 'cause', and the GP's role was to discover the nature of the problem – framed as a necessary step in order to meaningfully address the patient's self-harm.

> "…certainly, with both of these girls, my antennae are immediately up that there's something really awful going on, so my assumption is that this is a cry for help and a release mechanism, and I'm trying to treat it as such" **GP3**

> "There wasn't any legal problems or anything like that in household, so [a] fairly well, otherwise happy, healthy person [who became] very stressed in her teenage years and started to self-harm as a form of release from her anxiety" **GP14**

As indicated by the quotes from GP3 and GP14, the *absence* of any identifiable *social* problems, including abuse, led GPs to discuss self-cutting as relating to *psychological* issues – the management of emotions, a form of communication – and 'release' from stress or anxiety brought on by upheavals often attributed to reasonably typical teenage development. In contrast, other patients in this category might have their self-harm attributed more securely to identifiable 'social' problems.

> "She had been brought up in children's homes in [place], and not really had family support or contact. She was a very sad girl actually, and it was just her arms, but they were a terrible mess […] in some ways hers was more understandable, in a sense she had this very lonely, distressed, childhood." **GP5**

Thus, GPs' discussions of patients often spoke to a tension regarding whether this was a case of 'clinical' self-harm (related to psychological disturbance and emotional problems) or 'social' self-harm (related to social problems, such as abuse, bullying, parental problems, including parental substance use, and experience of being in care). Patients of all 'types' whose self-harm was framed as 'social' were more likely to be described as 'difficult', if available treatments or referrals were limited or entirely absent.

> "I had a girl who… [social problems with fitting in at school] she'd started cutting, and her, maybe her [mother] came, very upset that she was cutting, and again, wanting us to stop it immediately. But it's a more complex thing, and we can't get anyone to see her" **GP29**

In most cases, GPs suggested that young patients who self-harmed were referred on to psychiatry and described attempts to do so. Interestingly, this occurred even in cases where the GP expressed doubts as to whether such a referral was necessary.

> "She already had been referred for, or spoken about counselling at school, but they suggested seeing GP certainly as well, possibly, a psychiatrist. The mum was very, you know, willing. She'd made it obvious that she really did want a referral to be made. There was certainly no sign of any mental health issues with the girl, but she was also happy enough to speak to somebody at more length. So, referral" **GP12**

Where patients were referred on, there was a sense that this was a positive outcome, with the patient eventually moving away from self-harm, or at least being seen outside of primary care and therefore no longer a concern.

In contrast, cases where patients did not 'engage' or return for follow up were described as deeply troubling. In several cases GPs expressed concern that this reflected their own lack of 'skill' in providing support, or else they expressed frustration at the lack of available services to refer patients on to.

> "Every time you met the girl, you would be trying to do your best to help her really to move her forward, and you're very conscious of the fact that perhaps because she was so obviously not moving forward that it was something I was doing wrong, or it was my lack of skill, and that perhaps if I was somebody else or a skilled psychiatrist, I might be able to deal with it." **GP1**

The majority of patients in this type were female ('the girl'), though two young men were included in this category as they shared other features, described as: having cut themselves, attended consultation with their mother, and requiring some investigation into the 'causes' of the self-harm. However, there was some evidence that GPs may have responded to our questions about self-harm by focusing on 'young *female* self-cutting' in response to a widely held assumption that this is the demographic group more likely to 'self-harm' (where self-harm is understood as self-cutting). For instance, GP8 initially provided two practice examples focusing on young women who had cut themselves. In the final minutes of the interview, she mentioned another patient – an older man, who repeatedly self-harmed via self-cutting – but whom she had initially not considered:

> "From his young days, he has been doing it, and he just continues to do it now and again. Whenever he does self-harm the situation is taken out fresh that day whether he is intending to do anything. That's the reason I didn't get that possibly that example. I wasn't told about the age range. I just remembered him" **GP8**

Our study had deliberately not identified an 'age range' of patients we were interested in, but this indicates perhaps that some GPs 'read' the study as being about self-harm among younger patients,

mirroring the focus on this demographic group in clinical and popular representations (Chandler et al., 2011; Troya et al., 2019). Indeed, several GPs provided a third practice example (in addition to the two they were asked to consider in advance of the interview), and these additional cases were more likely to involve a broader range of patients in terms of age, gender and type of self-harm.

The problem patient

The second common type were 'problem patients' (n=20), who were generally older and described as having long-term health and social problems. Most (n=18) were female. GPs tended to express some pessimism about the long-term outlook for such patients. There was a fairly clear split among GPs in how they discussed these cases, with some GPs (n=6) describing themselves as fairly comfortable 'holding' such patients, even where there was no great expectation of any recovery. In many cases, however, GPs described these patients directly as 'problems' with whom they were often frustrated.

> "I don't know if I've ever done very much, but I don't know if I could have done very much. I've sort of done damage limitation with her. She has been referred, but I suppose she had to lead her own life really, and it is just sad to see people unable to lead it properly" **GP1**

> "She's got a label of personality disorder and she has had a lot of psychiatric involvement over the years but it doesn't change her behaviour and I just don't know how to deal with her" **GP21**

Patients in this category were framed as unable or unwilling to 'help themselves', a situation which led to frustration among some GPs. As with GP21, these patients also frequently had a 'label' of personality disorder, and were described as having had a considerable amount of intervention or support from psychiatry and community mental health teams. GPs sometimes indicated that they had put significant emotion work into managing their frustration with such patients:

> "So I try and get them to tell me and try just to be very non-judgmental and partial and try not to react either way, because I think that can affect how they disclose to you and it affects the relationship as well with the patient […] I guess, as a doctor, anyone hurting themselves, it sort of goes against, you know, how we treat people, we're always trying to make people feel better[…]when they are sort of cutting themselves or hurting themselves it always makes me feel personally a wee bit, ooh, you know, uncomfortable" **GP7**

The problem patient figure was present across accounts of GPs working in very diverse areas; there was variation, however, in the way these types of patients were described. For those GPs working in areas of deprivation, or with more marginalised communities, the 'problem patient' was described

as ‘the norm’, and GPs were more likely to provide accounts of ‘holding’ such patients relatively comfortably.

> “… we’re managing her in primary care, I think that’s...because I don’t think she’s going to be cured. I think it is a question of, as I’ve said to her, walking the journey with her, really. It’s not...she had a long history of being sexually abused and I think she’s incredibly damaged and I don’t think she will ever be, in inverted commas, well” **GP17**

Nevertheless, although GPs might be able to report working comfortably with ‘problem patients’ over long periods of time, some did explicitly discuss whether primary – or any medical – care should be the ‘first line’ in situations where patients were presenting with self-harm but facing often significant social problems:

> “Yes, and, I think, the solution has to be you need to stabilise them socially before you can access them medically, and psychologically, seems to be the kind of problems, but that’s a very trite answer for a very complex problem […] I think, that’s precisely the problem as a GP, it should never be your business at all, but you are the only gateway, the only sensible person that sometimes these people feel able to access” **GP26**

> “…there is that professional difficulty in just knowing how much you can respond, to what is a manifestation of some sort of malaise and this society we’re dealing with. Or, whether or not it’s a medical issue at all. It’s our problem” – **GP27**

For many GPs, the research interview appeared to be a welcome opportunity to discuss and reflect upon patients who self-harmed and were characterised as particularly problematic. These patients shared features which have been identified across other studies of ‘problem patients’: self-harm was described as part of a long-term, seemingly intractable or at least relapsing/recurring pattern; and treatment options were said to be limited, or else rejected by the patient. In some cases the patients’ problems were understood as being socially located, and therefore beyond the remit of medicine. Alongside this, as noted by GP26, was an understanding that, despite the inability of GPs to ‘successfully treat’ such patients, there was nonetheless an important role for them in maintaining a trusting and supportive relationship. This was particularly emphasised by GPs working with groups of patients who were marginalised as a result of insecure housing, drug problems or involvement with criminal justice. Indeed, among those who may be categorised as ‘problem patients’, there were varying degrees of empathy and understanding articulated in the research interviews.

There was some evidence that the context in which GPs worked played a significant role in shaping their affective responses. Of the six cases where GPs provided assured accounts indicating comfort working with 'problem patients', five were based in practices that served marginalised or disadvantaged communities. For instance, GP25, who worked in a specialist practice for marginalised patient groups, which allowed for longer consulting times and had an 'in-house' mental health team, spoke straightforwardly about how she and the practice as a whole worked with a woman who engaged in significant self-harm and drug misuse, and had regular attendances at A&E. Contrasting the specialist service where she worked with 'mainstream' GP, she noted:

> "it can be very difficult to manage that, both medically manage it, but also emotionally manage it, in the context of ten minutes, because you're carrying a high level of risk in a short space of time and, as a GP, that can often feel a little bit unsafe and a little bit unmanaged. So I think that there definitely is a gap in service provision for patients like that in mainstream general practice" **GP25**

In contrast, among other GPs working with 'problem patients' but in more affluent mainstream practices, there was a tendency to frame such patients as especially frustrating, perhaps because patients who were rejecting 'normal health-seeking' behaviour were more uncommon among their patients.

The 'out of the blue' suicide attempt

Cases that fell into this category involved male patients who had died by, or had planned or attempted, suicide. The acts involved were described by GPs as almost unequivocally aimed at suicide. The 'out of the blue' nature of many of these cases was reflected in the language used by GPs: these acts of self-harm (or suicide) were, in most cases, explicitly or implicitly 'surprising'. This was so, even in the context of long-term problems, including past self-harm.

> "I've known this guy for years but I'd been probably treating him for depression for about four or five months and there was no expectation at all of him wanting to self-harm in any way at all and the last time I had seen him things seemed to have been actually a bit better. So, it was all kind of a bit out the blue" **GP2**

One of the key differentiating features of patients categorised as 'out of the blue' was that their distress and any related self-harm was taken seriously; suicide was described as a very real concern. In contrast, patients in the other two types were far less likely to be framed as a significant suicide risk. For instance, GP18 provided an account of careful 'safety-netting' – discussing management of prescription drugs to avoid impulsive overdoses, attempting to refer the patient for support with

alcohol use (which was rejected by the patient) and community psychiatric support (which was also rejected). The patient was then described as going on to attempt suicide by hanging. While GP18 described feeling 'helpless' in this case, paralleling many of the 'problem patient' narratives above, there was a more pronounced undercurrent of concern that the patient might attempt suicide, and frustration with services (rather than the patient) for not taking the case more seriously.

> "He has declined referral to the community psychiatry nurse. The psychiatrist who saw him in the hospital – this is a classic I have to say – says that he is at high risk of impulsive self-harm, that there's no evidence of mental illness, and they've arranged no follow up. So this is a case where I feel that there's no satisfactory ongoing plan. I've tried to make it very clear that I, and we as a practice, are available as a source of help. He's declined other sources of help on at least two fronts with regard to his alcohol and CPN" **GP18**

> "Usually what happens is, you know, these people are seen once, advised that there's no treatable illness and they're discharged. So, they come back to us and there's been no change. You're still worried about them. They're going to do something. You've got a psychiatrist letter that says that there's, you know, there's nothing they can do. So, you know, no need to see again but these people still do occasionally go off and self-harm and sometimes kill themselves" **GP12**

While the patients in the other two categories were mostly female, the 'out of the blue' suicide was *always* male. In some cases, this involved a patient who died by suicide, with one GP providing an account which reflected on this case at length. This case underlined the significant effects that patient suicide can have on GPs, and the discursive and emotional labour that goes into attempting to understand such cases (Kendall & Wiles, 2010).

Similarly, some GPs discussed 'near misses', where a patient's act of self-harm was described as very nearly fatal. GPs often provided accounts which reflected critically on their own practice when treating patients who had self-harmed; in cases framed as explicitly related to suicide, these reflections were more serious:

> "you just have that angst about should you be doing more and the fact it was completely out of the blue because, you know, I'd been seeing him for about, I think, about four or five months and this was just suddenly totally unexpected and, you know, young men tend to do things to themselves sometimes. So, there's less of the cry for help that you would tend to maybe get with younger ladies" **GP2**

GP2 explicitly contrasts the 'out of the blue' case with female patients, whose self-harm is framed as more likely to reflect a 'cry for help' rather than a more 'serious' attempt at suicide.

Discussion

Based on our analysis of the ways in which GPs talked about different patients we identified three dominant 'types' of patients in these narratives: the 'good girl', the 'problem patient' and the 'out of the blue [suicide attempt]'. Our analysis suggests that the age and gender of patients presenting with self-harm may have a significant effect on how GPs make sense of the practice of self-harm, and indeed shape how they respond to patients. We found that younger patients were more likely to be described favourably, as 'good' patients – even where GPs expressed some ambivalence as to the clinical relevance of the practice of self-harm. The extent to which patients within the 'good girl' category were deemed 'good' or 'uncooperative' was related to the extent to which patients were viewed as engaging positively with GPs' attempts to help. In turn, the help offered by GPs can be related to the way in which they understood the patient's self-harm – as largely social or psychological in origin – and to the availability of services locally. GPs reflecting on all three types of cases noted the challenges they faced if patients could not be identified as having a 'treatable' mental illness and thus there was no appropriate place to refer on to.

Older patients were much more likely to be framed as 'problem patients'. In many cases, older patients were said to have long-standing, often seemingly intractable, medical *and* social problems. The subgroup of 'uncooperative girls', who may have been younger 'problem patients', was also described in this way. As with younger patients, GP's accounts considered whether older patients primarily represented people with 'medical' or 'social' problems. These patients' lives did appear more complex and challenging, but this led to significant frustration for some GPs, especially those working in practices located in more affluent areas, where patients with high levels of social and medical distress were less likely to be seen. Nevertheless, GPs working with more disadvantaged communities reflected critically on the limits of their ability to 'really help' patients who self-harmed in the context of difficult social circumstances.

> "The reason it's commoner in populations like ours, in deprived populations, is because people's lives are pretty unpleasant sometimes, very stressful, very difficult […] and then, there's the big grey area in the middle, of what do you do with just that huge basket load of patients who are struggling to cope and who serially misuse themselves" GP27

Questioning whether self-harm is (primarily) social or psychological in nature reflects long-standing trends in research examining doctors' attitudes towards patients who present with ambiguous symptoms or conditions, e.g. alcohol and drug use, and medically unexplained symptoms (MUS)

(Blaxter, 1978; Jeffery, 1979; Strong, 1980). This supports the identification of an enduring problematic, one that appears particularly relevant to primary care, where doctors feel compelled to sort patients according to whether medicine is able to offer an effective response. Unfortunately, as literature on MUS and chronic illness has argued, where doctors deem a patient's presenting problems to be primarily social in nature, they may feel frustrated and unable to offer help, potentially resulting in negative or dismissive treatment (May et al., 2004; Rasmussen & Ro, 2018).

An important qualification arising from our findings is the apparent existence of gender differences in how GPs discussed patients' self-harm, and the extent to which the deliberation regarding social or psychological causes of self-harm was deemed relevant. Our findings resonate with Jaworski's (2014) critical reflections on the gender of suicide – suggesting that gendered assumptions about suicidal intent and risk may play a role in clinical accounts of patients who self-harm. Although male patients were present in each of the more common types of patients described – the younger patient who cut themselves; the older patient who engaged in a more diverse range of long-term self-harmful practices and who was a 'heavy user' of services – female patients were not at all present among those we characterised as 'out of the blue' patients. There was some indication that the accounts GPs provided about this latter, smaller group of male patients involved taking self-harm among men as a more serious sign of distress, which represented a more significant chance of death by suicide. There were some cases where it was not clear whether a patient was an 'out of the blue' case or a 'problem patient' – there were some evident overlaps. However, in most cases GPs presented cases involving men as being much more clearly involving suicide risk as present and serious. In contrast, where suicide came up among mostly female 'problem patients' or 'good girl' patients, it was framed as a potentially accidental outcome of their self-harm, rather than an act that intentionally could result in death – even where patients were described as expressing suicidal thoughts.

Conclusion and limitations

This was a qualitative study of GPs working in two areas in Scotland. Findings may therefore not be generalisable to other areas of the UK, or indeed other national settings. However, participants were working in diverse geographic locations, from dense urban centres to remote rural communities. Although interviews were short, limited to 30 minutes, interviewees were used to conveying complex clinical detail in a very time-efficient way. As a result, the interviews generated surprisingly rich and reflective accounts.

Our study suggests that GPs' understanding of, and response to, self-harm is shaped by social and cultural framings of gender and age, as well as the different contexts in which GP practices are

located. Given the diverse but patterned ways in which GPs constructed accounts of self-harm, we suggest that training and awareness-raising among GPs should take into account and engage directly with the gender- and age-based assumptions that GPs may hold. While GPs' concern about potential suicide among male patients is warranted – reflecting higher rates of suicide among men - it may also be problematic. The association between self-harm and later suicide is found in both women and men, so assumptions that women who self-harm lack suicidal intent or have lower suicide risk may be ill-founded. Our study contributes further to research which is beginning to trouble assumptions in public discourse about gender and suicide, pointing out ways in which such assumptions may negatively impact on practice, via GPs' assumptions about lower risk among women (Jordan & Chandler, 2018; Mallon et al., 2016).

It is important to emphasise the significance of the context in which GPs were working as further shaping the types of accounts they provided. A concern with identifying self-harm as social or psychological in origin may in part reflect the way in which healthcare services, and psychiatric or mental health services in particular, are organised – e.g. as separate, with mental health services in particular chronically underfunded (Millard & Wessley, 2014). A concern with identifying self-harm as social or psychological in origin may reflect a form of triage being used by GPs in order to limit referrals to under-resourced mental health services and avoid the frustration of having referrals rejected for any but the most 'psychological' cases. This division according to perceived refer-ability thus perpetuates the otherwise largely spurious demarcation between 'social' and 'psychological' causes. Further, this approach may further entrench wider inequalities, if our finding that younger and less socially disadvantaged patients who self-harm are referred on more readily for psychological support is borne out in future research. Ultimately, services should be available to support patients who present with self-harm and are distressed without having to identify the origin of this distress. In some cases GPs were able to manage diffuse distress within primary care, but this was uncommon. We are unable to answer the question of whether GPs *should* 'hold' such distress within primary care. We suggest, however, that further work is needed to develop more effective supports for those who self-harm, without focusing needlessly on identifying the social or psychological origins of the practice.

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