Self-Harm and Conventional Gender Roles in Women

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A total of thirty-two women admitted to a general hospital for medical treatment after self-harming completed measures of conventional positive and negative masculinity and femininity. Comparisons were made with two control groups with no self-harm history; 33 women receiving psychiatric outpatient treatment and a nonclinical sample of 206 women. Multinomial logistic regression analyses showed that those with lower scores on Instrumentality and Unmitigated Agency (positive and negative masculinity) and higher scores on Insecurity (negative femininity) had greater odds of self-harming. Relationships were weaker after accounting for generalized self-efficacy. Results are discussed in relation to previous findings and suggestions for prevention are made.

Self-harm refers to a nonfatal act in which an individual deliberately initiates behavior or ingests a toxic substance or object with the intention of causing harm to him-or herself (Ystgaard, Reinholdt, Husby, & Mehlum, 2003). In most Western countries, women engage in self-harm more frequently than men (Canetto & Sakinofsky, 1998). Findings from a Norwegian hospital estimated the average annual rate of self-harm to be 50 per 100,000, for both sexes, with women having twice the incidence of men (Johannessen, 2011). Hypotheses for why women are at greater risk of self-harm than men include their greater propensity to depression (Jack, 1992), their choice of method of self-harm (Mościcki, 1994), and gender socialization (Canetto & Sakinofsky, 1998). In the present study we consider gender socialization theory, assessing whether particular conventional gender roles increase or decrease the risk of women engaging in self-harm requiring medical treatment. We focused on women, because women are at higher risk of engaging in self-harm than men.

Gender socialization theory suggests that we learn through our interactions with society how to be a man or a woman (Canetto & Sakinofsky, 1998). Cultural gender scripts help shape which traits and behaviors, including self-destructive behaviors, are more appropriate for men or women. Conventional femininity is tied up with notions of dependency and indecisiveness. Interpersonal communication is central to the feminine gender role and self-harming is often seen as a way of communicating one’s distress (Scourfield, Jacob, Smalley, Prior, & Greenland, 2007). In contrast,
conventional conceptions of masculinity suggest that men are expected to be independent, strong, and decisive. When faced with significant life stressors then, men may be more reluctant than women to convey their problems or appear weak (Möller-Leimkühler, 2003). As such, self-harming may be incompatible with the conventional masculine gender role (Möller-Leimkühler, 2003), but more fitting with the feminine (Canetto & Sakinofsky, 1998). Previous research suggests that self-harm is indeed seen as feminine (Canetto, 1997; Scourfield et al., 2007) and that people are more sympathetic toward young women than toward men, who have self-harmed (Canetto, 1997).

Empirical studies typically measure Instrumentality (or Agency) and Expressiveness (or Communion) as proxy measures of conventional masculinity and femininity, respectively. While a Polish study found that women in psychiatric treatment who had self-harmed scored lower on Instrumentality than women in a community sample, the researchers found no differences in Expressiveness scores (Mandal & Zalewska, 2010). A similar relationship has been found for suicidal ideation in the general population in Scotland (Hunt, Sweeting, Keoghan, & Platt, 2006), while a study from the United States found that feminine women were less likely to report self-harming or suicidal ideation than masculine women (Street & Kromrey, 1995).

Straiton, Roen, and Hjelmeland (2012) proposed that we may better understand gender socialization theory in relation to self-harm if we conceptualize gender roles in terms of both positive and negative aspects of masculinity and femininity. Previous studies had only measured positive aspects. In a nonclinical Norwegian sample, positive and negative masculinity (Instrumentality and Unmitigated Agency, respectively) were negatively associated with the risk of lifetime self-harm and self-harm within the last year. Negative femininity (Insecurity) was positively associated with self-harm, but positive femininity (Communion) was unrelated. Thus, the positive aspects of conventional femininity such as expressiveness and concern for others were not related to the risk of self-harm, negative aspects such as overdependence on others or anxiety were. The sample in this study was very broad, although it included both men and women, of whom the majority had never required medical treatment due to self-harming and had self-harmed some time ago.

The current study focused on a more specific group: women who were recently admitted to hospital for medical treatment as a result of self-harming. Mandal and Zalewska (2010) also looked at a female clinical sample, although the women were also in psychiatric treatment and were compared with a community sample. This comorbidity of self-harm and psychiatric disorder makes it unclear whether the observed difference in Instrumentality was related specifically to self-harm or to having a psychiatric disorder (because one can occur without the other).

The aim of the current study was to determine whether positive and negative aspects of conventional masculinity and femininity are associated with medically treated self-harm in women. The WHO/EURO Multicentre Study definition was used to define self-harm:

An act with non-fatal outcome in which an individual deliberately initiates a non-habitual behavior, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes that the person desires via the actual or expected physical consequences. (Platt et al., 1992, p. 99).

We compared a group of women who recently received medical treatment after engaging in self-harm with two control groups with no self-harm history; a group of women attending a psychiatric outpatient clinic and a convenience nonclinical Internet sample. More specifically, as found in a nonclinical sample (Straiton et al., 2012), we hypothesized that Instrumentality and Unmitigated Agency would
be negatively related to the risk of self-harm, while Insecurity would be positively related to the risk of self-harm. Communion would be unrelated.

There are many variables that may confound the relationship between gender roles and self-harm. This study considered several that have previously been associated with self-harm including generalized self-efficacy (Dieserud, Roysamb, Ekeberg, & Kraft, 2001), social support (Groholt, Ekeberg, Wichstrom, & Haldorsen, 2000), help-seeking (Evans, Hawton, & Rodham, 2005), and problematic alcohol use (Haw, Hawton, Casey, Bale, & Shepherd, 2005). These factors may also be related to conventional gender roles (Choi, 2004; Reevy & Maslach, 2001; Williams & Ricciardelli, 2003). Therefore, in addition to controlling for important demographic variables, we considered whether these gender-related psycho-social factors confound the relationship between the gender roles and self-harm.

METHOD

Participants

Group 1 (self-harm group): Thirty-two women recently admitted to a general hospital for medical treatment after having engaged in self-harm [as determined by the WHO/EURO definition (Platt et al., 1992)]. Ages ranged from 20 to 58 years (mean = 32.06, SD = 10.93).

Group 2 (psychiatric outpatient group): Thirty-three women attending outpatient appointments at a psychiatric clinic with no self-harm history. Ages ranged from 18 to 48 years (mean = 27.48, SD = 6.65), although age was not provided by two participants.

Inclusion criteria required patients in both groups to be Norwegian speaking and literate. Those with psychosis, illegal drug addiction, or learning difficulties that could lead to problems in understanding the questionnaire were excluded.

Group 3 (nonclinical control group): A nonclinical control group consisting of a subsample of 206 women who completed an online questionnaire and answered no to the following question: Have you ever deliberately taken an overdose (e.g., of pills or other medication) or tried to harm yourself in some other way (such as cut yourself)? Two participants in this group were over 40 years, although exact age was not reported. For those 18 to 40, the mean age was 25.49 years (SD = 5.21).

Measures

Demographics. Age, civil status, sexual orientation, educational attainment, and employment status were analyzed with the following measures.

The Australian Sex Role Scale (ASRS; Antill, Cunningham, Russell, & Thompson, 1981) was originally a 50-item scale containing four 10-item gender-specific subscales: positive masculine (M+), positive feminine (F+), negative masculine (M−), and negative feminine (F−); and two 5-item gender neutral subscales: socially desirable (S+) and socially undesirable (S−). Items are rated on a scale of 1 (never/almost never true) to 7 (always/almost always true) for level of endorsement. The scale was previously adapted and shortened for a Norwegian population using another sample of similar age (Straiton, 2012). Four of the five confirmed factors reflect some elements of conventional gender roles and are used here. Instrumentality (Firm, Strong, Good in Business and Responsible) (α = 0.63) is considered a positive part of conventional masculinity. Unmitigated agency (Outspoken, Sees Self-running the Show, Aggressive, Competitive, Boastful, and Feels superior) (α = 0.78) is considered a negative part of conventional masculinity. Communion (Loves Children, Grateful, Sensitive to the Needs of Others, and Devotes Self to Others) (α = 0.54) and Insecurity (Carefree [negative loading], Worried, Nervous, Emotional, Needs Approval, Self-critical, and Weak) (α = 0.77) are considered the positive and negative factors of conventional
femininity, respectively. Mean scores for each of these factors can range from 1 to 7, where a higher score indicates higher endorsement.

The augmented CAGE (Bradley, Bush, McDonell, Malone, & Fihn, 1998) questionnaire determines whether respondents’ alcohol use is at a harmful level. Participants are asked five questions about their drinking habits, for example, Have you ever felt you should cut down on your drinking? One point is given for each positive response. Two additional items assess average alcohol intake based on quantity and frequency of drinking. Women who drink on average more than 14 units of alcohol per week or drink five or more units on a typical drinking day are given one point. Participants with two or more points are then classed as harmful alcohol users.

The Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988; α = 0.94) is a 12-item questionnaire assessing perceived support from family members, friends, and a significant other. Participants respond on a scale of 1 (completely disagree) to 5 (completely agree). Mean score ranges from 1 to 5, where higher scores indicate higher social support.

The General Help-Seeking Questionnaire (GHSQ) (Wilson, Deane, Ciarrochi, & Rickwood, 2005) measures help-seeking intentions. Questions can be adapted according to the relevant help-seeking problem. Here, the two questions related to help-seeking for depression/anxiety and help-seeking for suicidal thoughts. Participants indicated on a scale of 1 to 7 how likely they would be to seek help from the following sources: partner, friend, parents, another family member/relative, mental health worker, helpline, doctor, or no one. These sources can be divided into three subscales: (1) help-seeking from formal sources (mental health professional, doctor, or helpline; α = 0.82) (2) help-seeking from informal sources (partner [if applicable], friend, parents, or other family member/relative; α = 0.74/0.79 [with/without partner]); and (3) no help-seeking (no one; α = 0.61). Mean scores for each source were calculated, where seven indicates highest likelihood of help-seeking.

The Generalized Self-efficacy (GSE) scale (Schwarzer, 1994; α = 0.90) is a 10-item measure assessing optimistic self-beliefs of one’s own ability to cope with demands in life. Participants indicate their agreement with each statement on a scale of 1 (not at all true) to 4 (exactly true). Mean score is calculated, where a value of four indicates high self-efficacy.

Suicidality (group 1 only) was assessed by asking participants to what extent “I wanted to die” played a role in the decision to self-harm. This could be answered on 3-point scale from no influence to a large influence. The question is derived from Bancroft, Skrimshire, and Simkin’s (1976) previous work looking at self-harming intentions.

Procedure

There were eight general hospital departments around Norway involved in data collection at different time points over a 2-year period. A health care professional informed women meeting the inclusion criteria about the study before discharge from hospital. Those who wished to participate were issued written information about the study and the questionnaire. The completed questionnaire was returned to a staff member in a sealed envelope before leaving the hospital. The staff collated and sent all completed questionnaires back to the research group.

Psychiatric outpatients with no self-harm history were informed about the study by their health care provider during an appointment at one of the four participating outpatient clinics in the South East region of Norway. Those who wished to participate were issued the questionnaire together with the written information about the study and encouraged to fill in the questionnaire at the clinic. The completed questionnaire was returned to the clinic in a sealed envelope. These were collated at the clinic and sent to the research group.
In the nonclinical sample, participants were recruited via online advertisements for participation in a study with the Norwegian Institute of Public Health. Advertisements were posted on online newspapers, debate forums, social networking Web sites, and general interest Web sites. Further information about the study could be obtained by clicking on the link provided. Participants confirmed that they were over 18 years old and gave their consent for participation before completing the questionnaire electronically. Participation was anonymous, and data were only stored if the participant reached the end of the questionnaire.

Ethical Considerations

Ethical approval for this study was granted by the Regional Committee for Medical and Health Research Ethics, South East Norway. All participants received written advice about who to contact in the event of distress. Both patient groups were also given the opportunity to talk to their health care provider after participation.

Analysis

Analysis was conducted in SPSS Statistics for Windows, Version 17 (Chicago: SPSS Inc.).

Missing Data. To allow the maximum number of participants to be included in analysis, missing variables were estimated and imputed. One participant in group 1 was missing information about civil status and was estimated and imputed as single, based on other demographics. Four participants (three in group 1, one in group 3) had not completed enough data to determine harmful alcohol use. Participants missing more than 60% of data on other subscales were excluded from any analysis involving that subscale. Five participants (three in group 1, two in group 3) were missing data for perceived social support, and three (all in group 1) for generalized self-efficacy. For help-seeking from formal and informal sources, nine participants were missing data (seven in group 1, one in group 2, and one in group 3). Thirteen people were missing data for no help-seeking (seven in group 1, two in group 2, and four in group 3).

Main Analysis. Multinomial logistic regression analysis was used as this allows statistical testing across a multi-category dependent variable (group) by both continuous and categorical independent variables. Group 1, the self-harm group was the reference category.

The main variables of interest were scores on the four gender role subscales (Instrumentality, Unmitigated Agency, Communion and Insecurity). The proposed psychosocial confounders included: harmful alcohol use (Yes/No); perceived social support (SSup), generalized self-efficacy (GSE), help-seeking formal sources (HSfrm), help-seeking informal sources (HSinf), and no help-seeking (noHS) (all continuous). Separate analyses were conducted for each gender role variable and psychosocial confounder to compare the self-harm group with each control group. This was performed both before and after controlling for the demographic variables. Significant gender role variables were then entered simultaneously to check their importance while controlling for other gender role variables. All significant predictors were then entered into the final multivariate analysis to see if the gender role variables were still significant after accounting for the potential confounders. It should be noted that due to the small number of patients in both groups, the analyses involving these two groups lack power. Nonetheless, it was deemed theoretically important to include group 2, but the findings should be considered preliminary.

RESULTS

Sample Characteristics

Nineteen (59%) of the women in the self-harm group reported that wanting to die had played a strong role in their decision
to self-harm, six (19%) said it had a little influence, and five (16%) reported it did not influence their decision. The remaining two women did not answer the question.

Although age was a significant predictor of group status ($X^2 = 20.33$, $df = 2$, $p > .001$), this is a result of pre-existing group differences. As such, it is systematically associated with the dependent variable. Thus, to avoid overadjusting, we omit this from further analyses. The demographic characteristics of the three groups along with the means and standard deviations of the gender role and other psychosocial factors are shown in Table. In univariate multinominal logistic regression analyses, log-likelihood ratio tests indicated an overall significant relationship between group status and civil status ($X^2 = 14.78$, $df = 2$, $p > .01$), educational attainment ($X^2 = 32.13$, $df = 2$, $p > .001$), and employment ($X^2 = 51.25$, $df = 2$, $p > .001$).

### Table 1

Sample Characteristics and Means and Standard Deviations (SD) for Gender Role and Other Psychosocial Variables

<table>
<thead>
<tr>
<th>Sample characteristics</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
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<tbody>
<tr>
<td>Civil status**</td>
<td>$n$ (%)</td>
<td>$n$ (%)</td>
<td>$n$ (%)</td>
</tr>
<tr>
<td>Single</td>
<td>27 (85)</td>
<td>14 (42)</td>
<td>110 (53)</td>
</tr>
<tr>
<td>Married/cohabiting</td>
<td>5 (16)</td>
<td>19 (58)</td>
<td>96 (47)</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>27 (85)</td>
<td>32 (97)</td>
<td>186 (90)</td>
</tr>
<tr>
<td>Gay/lesbian/bisexual</td>
<td>5 (16)</td>
<td>1 (3)</td>
<td>20 (10)</td>
</tr>
<tr>
<td>Employment***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently working/studying</td>
<td>11 (34)</td>
<td>15 (45)</td>
<td>177 (86)</td>
</tr>
<tr>
<td>Not currently working/studying</td>
<td>21 (66)</td>
<td>18 (55)</td>
<td>29 (14)</td>
</tr>
<tr>
<td>Educational attainment***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower</td>
<td>29 (91)</td>
<td>27 (82)</td>
<td>101 (49)</td>
</tr>
<tr>
<td>Higher</td>
<td>3 (9)</td>
<td>6 (18)</td>
<td>105 (51)</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Gender role variables</th>
<th>Mean (SD)</th>
<th>Mean (SD)</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumentality***</td>
<td>4.46 (1.01)</td>
<td>4.89 (0.87)</td>
<td>5.15 (0.77)</td>
</tr>
<tr>
<td>Communion</td>
<td>5.26 (1.39)</td>
<td>5.26 (0.83)</td>
<td>5.17 (0.83)</td>
</tr>
<tr>
<td>Unmitigated agency***</td>
<td>2.37 (0.76)</td>
<td>2.77 (0.86)</td>
<td>3.16 (0.84)</td>
</tr>
<tr>
<td>Insecurity***</td>
<td>5.27 (1.19)</td>
<td>5.09 (1.01)</td>
<td>4.40 (1.00)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other psychosocial variables</th>
<th>Mean (SD)</th>
<th>Mean (SD)</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Social support***</td>
<td>3.32 (0.84)</td>
<td>3.72 (0.70)</td>
<td>4.12 (0.83)</td>
</tr>
<tr>
<td>Help-seeking, formal sources$^d$</td>
<td>3.27 (1.71)</td>
<td>4.22 (1.34)</td>
<td>3.78 (1.56)</td>
</tr>
<tr>
<td>Help-seeking, informal sources**</td>
<td>3.54 (1.44)</td>
<td>4.26 (1.43)</td>
<td>4.51 (1.45)</td>
</tr>
<tr>
<td>No help-seeking</td>
<td>3.13 (2.11)</td>
<td>2.59 (1.74)</td>
<td>2.71 (1.83)</td>
</tr>
<tr>
<td>Generalized self-efficacy***</td>
<td>2.37 (0.54)</td>
<td>2.69 (0.45)</td>
<td>3.11 (0.45)</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Harmful alcohol use$^d$</th>
<th>$n$ (%)</th>
<th>$n$ (%)</th>
<th>$n$ (%)</th>
</tr>
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<tbody>
<tr>
<td>No</td>
<td>20 (67)</td>
<td>28 (85)</td>
<td>172 (84)</td>
</tr>
<tr>
<td>Yes</td>
<td>10 (33)</td>
<td>5 (15)</td>
<td>33 (16)</td>
</tr>
</tbody>
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$^a$Self-harm group.
$^b$Psychiatric outpatient group.
$^c$Nonclinical control group.
$^d$$p < .1$, *$p < .05$, **$p < .01$, ***$p < .001$. 
<table>
<thead>
<tr>
<th></th>
<th>Group 1&lt;sup&gt;a&lt;/sup&gt; vs. Group 2&lt;sup&gt;b&lt;/sup&gt;</th>
<th></th>
<th>Group 1&lt;sup&gt;a&lt;/sup&gt; vs. Group 3&lt;sup&gt;c&lt;/sup&gt;</th>
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<tbody>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>OR (95% CI)</td>
<td>AOR (95% CI)</td>
</tr>
<tr>
<td>Gender role variables</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Instrumentality</td>
<td>1.82 (1.01–3.26) *</td>
<td>1.68 (0.91–3.12)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>2.70 (1.69–4.32) ***</td>
<td>2.35 (1.38–4.00) ***</td>
</tr>
<tr>
<td>Communion</td>
<td>1.00 (0.58–1.73)</td>
<td>0.89 (0.52–1.53)</td>
<td>0.91 (0.60–1.37)</td>
<td>0.84 (0.54–1.32)</td>
</tr>
<tr>
<td>Unmitigated agency</td>
<td>2.01 (1.04–3.89) *</td>
<td>1.84 (0.90–3.79)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>3.56 (2.05–6.18) ***</td>
<td>2.89 (1.53–5.46) **</td>
</tr>
<tr>
<td>Insecurity</td>
<td>0.84 (0.51–1.37)</td>
<td>0.84 (0.49–1.44)</td>
<td>0.43 (0.29–0.64) ***</td>
<td>0.39 (0.24–0.64) ***</td>
</tr>
<tr>
<td>Other Psychosocial variables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harmful alcohol use</td>
<td>0.36 (0.11–1.21)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>0.38 (0.10–1.41)</td>
<td>0.38 (0.17–0.89) *</td>
<td>0.37 (0.13–1.03)&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Perceived social support</td>
<td>1.57 (0.92–2.68)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>1.31 (0.72–2.38)</td>
<td>2.75 (1.77–4.27) ***</td>
<td>1.90 (1.13–3.21) *</td>
</tr>
<tr>
<td>Help-seeking, formal sources</td>
<td>1.06 (1.06–2.12) *</td>
<td>1.42 (0.98–2.07)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>1.24 (0.94–1.63)</td>
<td>1.26 (0.92–1.73)</td>
</tr>
<tr>
<td>Help-seeking, informal sources</td>
<td>1.40 (0.97–2.02)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>1.25 (0.86–1.83)</td>
<td>1.58 (1.18–2.13) **</td>
<td>1.37 (0.99–1.89)&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>No help-seeking</td>
<td>1.01 (0.78–1.32)</td>
<td>1.07 (0.81–1.41)</td>
<td>0.85 (0.69–1.06)</td>
<td>0.88 (0.70–1.12)</td>
</tr>
<tr>
<td>Generalized self-efficacy</td>
<td>3.96 (1.31–11.95) *</td>
<td>3.29 (0.97–11.23)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>29.83 (10.11–88.03) ***</td>
<td>30.16 (8.38–108.62) ***</td>
</tr>
</tbody>
</table>

<sup>a</sup>self-harm group.  
<sup>b</sup>psychiatric outpatient group.  
<sup>c</sup>nonclinical control group.  
<sup>d</sup>p < .1, *p < .05, **p < .01, ***p < .001.
Gender Roles and Other Psychosocial Factors

The odds ratios and confidence intervals for each of the gender role variables and psychosocial factors are shown in Table 2. These are given before and after adjusting for the demographic variables. Because the self-harm group is the base category, odd ratios over 1 suggest higher odds of not being in the self-harm group, and thus lower odds of being in the self-harm group as the independent variable increases. Values under 1 suggest higher odds of being in the self-harm group.

Even after adjusting for the relevant demographics, Instrumentality, Unmitigated Agency, and Insecurity were predictors for groups 1 and 3, supporting our initial hypotheses. Those scoring high on Instrumentality and Unmitigated Agency had lower odds of being in the self-harm group while those high on Insecurity had higher odds. For groups 1 and 2, the relationships were in the same direction, although Instrumentality and Unmitigated Agency were the only gender roles variable showing a tendency predicting group status after adjusting for the demographics. Relationships may have been stronger in a larger sample.

With regard to the other psychosocial variables, after controlling for demographics, SSUP and GSE significantly predicted group status for group 1 and group 3, with the odds of self-harming increasing as SSUP and GSE scores decreased. For groups 1 and 2, GSE and HSfrm tended to predict group status. Those with higher help-seeking scores had higher odds of being in groups 2. Again, these tendencies may have been significant in a larger sample.

Multivariate Model

Although Instrumentality, Unmitigated Agency, and Insecurity were predictive of group status for groups 1 and 3 in separate analyses, when all three of these variables were included, Instrumentality was no longer an overall significant predictor ($X^2 = 2.05, df = 2, p > .05$).

The final analysis included therefore Insecurity, Unmitigated Agency, SSUP, and GSE, while adjusting for demographics. As shown in Table 3, for groups 1 and 3, Insecurity and GSE were still significant predictors of self-harm. There was also a tendency for Unmitigated Agency to predict self-harm. For comparisons with group 1 and 2, because power was particularly low, there were no significant relationships or tendencies. Relationships were in the same direction as the group 1 and group 3 comparisons.

DISCUSSION

The study aimed to assess the relationship between positive and negative
aspects of gender roles and self-harm among women. Our hypotheses were partially supported; women who were recently treated in a general hospital after self-harming scored significantly higher on Insecurity and lower on Unmitigated Agency (and lower on Instrumentality prior to accounting for other gender role variables) than women in the nonclinical sample who had never self-harmed. Although not significant, relationships were in the same direction when compared with women attending a psychiatric outpatient clinic who had never self-harmed. The results indicate that different aspects of gender roles relate to self-harm in different ways, which is in line with previous findings for suicidal thoughts and self-harm in nonclinical samples (Galligan, Barnett, Brennan, & Israel, 2010; Straiton et al., 2012). This study appears to be the first to consider a hospital-treated self-harm sample of women, and to include both a clinical and nonclinical control group. Although we have no direct information regarding the method of self-harm these women used, the majority are likely to be self-poisoning cases. Up to 95% of patients treated for self-harm in the participating hospitals use self-poisoning (Dieserud, Loeb, & Ekeberg, 2000; T. Grimholt, personal communication; December 12, 2011; S. Z. Medby, personal communication, January 10, 2012). Most of the sample suggested that they had some level of suicidal intent when harming themselves, although the WHO definition we used includes both suicidal and nonsuicidal self-harm.

Insecurity was the gender role variable with the strongest relationship to self-harm after accounting for other psychosocial variables. However, it was not significantly associated with self-harm in the comparisons between the self-harm and psychiatric outpatient groups. This may suggest high Insecurity is not specific to self-harm, but related to mental health difficulties. Alternatively, as the relationship was in the same direction, our lack of significant finding may have been due to the small sample sizes for these two groups. As previously found, Communion was unrelated to self-harm (Straiton et al., 2012). This may indicate that while aspects of expressiveness and communion in the conventional feminine gender role are unrelated to self-harm, negative aspects related to insecurity could be a risk factor.

Mandal and Zalewska (2010) found that women who had self-harmed and were in psychiatric treatment scored lower on Instrumentality than women in a community sample. It was not clear as to whether this difference was specific to women who have self-harmed or to women with a psychiatric disorder. While the two are often linked (Haw, Hawton, Houston, & Townsend, 2001), not everyone with a psychiatric disorder self-harms (Brodky et al., 2001), and not everyone who self-harms has a psychiatric disorder (Nordentoft & Rubin, 1993). By including the psychiatric outpatient control group in our study, we were able to assess whether the lower scores on Instrumentality were specific to self-harm. The self-harm group scored significantly lower on Instrumentality than both the control groups, although the mean scores suggest that Instrumentality was also higher among the nonclinical group than the psychiatric group. Low Instrumentality may only be partially specific to self-harm. Regardless, generalized self-efficacy appeared to be confounding the relationship.

Unmitigated Agency was negatively related to self-harm in both control groups, but it has been previously positively associated with antisocial behavior (Spence, Helmreich, & Holahan, 1979) and alcohol abuse in teenagers (Williams & Ricciardelli, 2003). As such, for risk of being seen as weak, it may be that some women high on Unmitigated Agency engage in other self-destructive, externalizing behaviors that are associated with masculinity in times of emotional difficulties. In contrast, internalizing emotions can lead to self-blame and subsequent self-harm (Hintikka et al., 2009; Laye-Gindhu & Schonert-Reichl, 2005). Internalizing is more commonly associated with the conventional feminine gender role
(Rosenfield, 2000) and thus may explain the association between Insecurity and self-harm. Future research on gender roles may therefore benefit from the inclusion of externalizing and internalizing measures.

This study focused only on women, but it would be of interest to assess these relationships in a sample of men too, because some studies suggest that men’s injuries following hospital-treated self-harm are more lethal (Haw, Hawton, Houston, & Townsend, 2003). Galligan et al. (2010) found that Instrumental aspects of the masculine gender role such as motivational drive may protect against suicidal ideation in young men, while other aspects such as being anxious about emotional disclosure may be detrimental. Further, a Canadian study found that strongly adhering to the masculine gender role was actually positively associated with hospital-treated self-harm among a sample of men (Houle, Mishara, & Chagnon, 2008). This suggests that the masculine gender role in general may not always be a protective factor for self-harm. These studies, together with the current study, highlight the importance of thinking beyond the male/female distinction in research and to considering different aspects of gender.

Generalized self-efficacy was the strongest predictor of self-harm and appeared to confound the relationship between self-harm and Instrumentality. Dieserud et al. (2001) also found self-efficacy to be related to self-harm among patients treated in hospital. Poor interpersonal problem-solving skills appeared to mediate the relationship. Thus, interventions focusing on problem-solving skills and alternative coping strategies among people at low to moderate risk of self-harm are advisable (Dieserud et al., 2001). We found harmful alcohol use to only be significantly related to self-harm before adjusting for demographics. We would have expected a stronger association, as alcohol problems are often linked to self-harm (Haw et al., 2005). Social support, usually considered an important protective factor against self-harm (King & Merchant, 2008), was related in this study before accounting for the gender roles and self-efficacy. In terms of help-seeking, the self-harm group tended to have lower informal help-seeking intentions than the nonclinical sample. This could also be related to social support, in that if one has a low sense of support, one may feel isolated, and thus have fewer informal sources available. Conversely, the psychiatric group tended to have higher formal help-seeking intentions than the self-harm group. This is unsurprising given that those in the outpatient group are in treatment and have therefore sought help for their problems. The ability to seek professional help, and subsequently obtain it, may be protective of self-harm when experiencing emotional difficulties. Reducing the barriers to help-seeking from formal sources may therefore be an important preventative strategy for at-risk groups.

There are a number of limitations in this study. First, the study relied on data from a small number of participants in each of the two patient groups. This resulted in insufficient power to detect important associations between these groups, particularly in the multivariate analyses. The findings for these groups are therefore preliminary and require replication in a larger sample. A non-psychiatric clinical control patient group may also be a useful comparison group in future studies. Second, the patients recruited in this study may not be representative of other women receiving medical treatment after self-harming. The response rate across hospitals is not known, so we do not know if there were differences between those who chose to and not to participate. Additionally, the health professionals involved in data collection at the hospitals had to be available to introduce the study to the patient before they were discharged. This was not always possible, meaning patients were not consecutively approached. There may also have been inconsistencies across health professionals’ assessments of patients’ suitability for both the definition of self-harm and the inclusion criteria, particularly because data collection took place across a number of hospitals. Several
hospitals were necessary for data collection due to the small number of patients fitting inclusion criteria for the study and the availability of personnel. It is also noteworthy that the women in the self-harm group were on average older than the women in the other groups. This is unusual because self-harm is thought to peak in late adolescence/early adulthood (Hjelmeland, 2004) but is likely to be due to sampling differences.

Another important limitation is the use of the ASRS. This scale was developed for an Australian population, and while it has been adapted for a Norwegian sample (Straiton, 2012), validity requires ongoing investigation (Kane, 2001). Communion in particular had low reliability. Finally, while the findings suggest an association among gender roles, other psychosocial factors, and self-harm, causality cannot be determined from this retrospective data. Although gender roles may be assumed to be fairly stable (McCrae, 1993), one’s perceptions may be altered according to experiences. People may rate themselves higher on Insecurity and lower on Instrumentality/Unmitigated Agency immediately following self-harm, especially considering self-harm may be viewed negatively by others (Canetto, 1997). Furthermore, some participants in the self-harm group may have self-harmed on previous occasions. There could be a continuous cycle of high Insecurity increasing the risk of self-harm and self-harm increasing feelings of Insecurity, which in turn increases the risk of self-harm. Plus, low sense of self-efficacy may lead to an individual using the same coping strategy of self-harm (Dieserud, Roysamb, Braverman, Dalgard, & Ekeberg, 2003), which can subsequently reduce self-efficacy and increase Insecurity.

CONCLUSION

It has been suggested that women self-harm more than men because of the way they are socialized. It is therefore assumed that the feminine gender role is a risk factor for self-harm or that masculinity is protective. However, this study suggests that it is only specific aspects associated with conventional negative femininity that may relate to self-harm among women, although these aspects may also be indicative of poorer mental health in general. Gender socialization begins at a young age, so strategies aimed at encouraging instrumental traits (and discouraging over reliance on others) may be important. A balance should be sought that also encourages expressiveness, because other studies show that “overmasculinized” behavior may be a risk factor for other self-destructive behaviors.

REFERENCES


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