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PERCEPTIONS OF DELIBERATE SELF-HARM IN THAILAND: THE ROLE OF GENDER AND PUBLIC STIGMAS

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ABSTRACT

Previous studies on the general public's perception of self-harm have focused on "nonsuicidal self-injury" (NSSI). Research on "deliberate self-harm" (DSH) as a form of impulsive non-lethal suicide has rarely been examined. To address the paucity of literature available within the Asian context, the present study examined the Thai general public's perception toward acts of DSH in the context of failed suicide attempts. The central question of this study is "how do members of the Thai general public perceive impulsive acts of DSH with suicidal intent?" One hundred twenty-six Thais completed the attribution model of public discrimination questionnaire as adopted from a study by Corrigan et al. (2003). The present study employed two vignettes and compared male and female responses to acts of DSH. Assessments were made in regards to the attribution of: 1) personal responsibility beliefs (PRB); 2) affective responses (e.g., pity, anger, and fear); and 3) coercion-segregation responses toward persons who committed acts of DSH. Independent sample t-test showed a significant difference in Thai men and women's attribution of helping responses.

Keywords: Self-harm, suicide, psychology, culture, perceptions, Thailand

INTRODUCTION

Each year, 25,000 to 27,000 Thais deliberately harm themselves, which is the fourth leading cause of Thai adolescent death (Thanoi et al. 2010). According to Erik Erikson's stages of psychosocial development (1963, 1968, as cited in Portes et al. 2002), there are eight developmental stages within the human lifespan. Each stage consists of a crisis that needs to be resolved, and failing to do so negatively impacts the individual. The aetiology of self-harm and suicide can be seen as a psychosocial crisis of the identity versus role confusion stage and the resultant failure to establish a coherent sense of identity (Claes et al. 2014; Portes et al. 2002). Congruent with the study of Thanoi et al. (2010), emotional distress is a predictor of Thai adolescent suicide risk behaviours, whereby youths between the age of 15 and 24 are particularly at risk for suicide-related behaviours such as DSH (Tittabut 2011).

The role of gender in mental illness stigmatisation is well-documented within the western context (Wirth and Bodenhausen 2009). However, little is known about the public perceptions of gender-based stigmatisation of DSH within Asia. Previous research on stigmatisation in Thailand (Pitakchinnapong and Rhein 2019; Pruksarungruang and Rhein 2022) indicates a prevalence of stigmatising those suffering from mental health issues. An analysis of the public stigma in terms of related stereotypes, prejudices, and discrimination is helpful to the elucidation of current mental health trends. Previous sex research-based mental illness stereotypes have found that males are more likely to be stereotyped as aggressive or violent, and females are more likely to be stereotyped as pitiful and dependent (Ottati et al. 2005). The general conceptualisation of mental illness and the varying responses to reading vignettes of males and females who deliberately self-harm is important as it may indicate how those suffering from mental health issues will be treated in different circumstances. Past studies on the general public's perceptions of self-harm have predominantly been conducted within the West, with particular emphasis given to acts of "nonsuicidal self-injury" (NSSI) with no regard to suicidality. Due to insufficient exploration of the Thai general public's perception of acts of DSH, minimal empirically supported claims exist within this study area. The current study aims to fill the gap within the existing literature by examining the Thai perception of DSH by comparing male and female-based vignettes.

LITERATURE REVIEW

Various definitions of the self-harm phenomenon exist and are often used interchangeably as researchers, and mental health professionals have not agreed upon a standardised term to identify the behaviour (Hagell 2013; Simeon et al. 1992; Simpson 2001; Zlotnick et al. 1996 as cited in Gratz 2001). "Self-harm" refers to the self-infliction of pain or injury onto bodily tissue whereby the infliction of physical pain is done to alter the individual's mood state and is committed without suicidal intent (Hagell 2013; Smith 2016). On the other hand, DSH is an umbrella term encompassing a range of behaviours in which an individual deliberately harms oneself, whether it be with or without the suicidal intent, that does not result in the death of the individual (Brooksbank 1985; Black et al. 1982; Health Service Executive, the National Suicide Review Group and Department of Health and Children 2005).

NSSI is another term used to refer to the intentional attempt to harm one's body without any suicidal intent, diminishing the co-occurrence of the behaviour with attempted suicide (Halicka and Kiejna 2018; Klonsky et al. 2014; Peterson et al. 2008). Acts of self-harm are often referred to as "nonsuicidal self-injury" (NSSI) in studies conducted within the U.S., while studies in Europe use the term "deliberate self-harm" (Hagell 2013). The lack of standardised nomenclature results in the interchangeable usage of terms when referring to a single concept. This lack of standardisation is particularly problematic as acts of DSH may contain suicidal intent while NSSI does not (Halicka and Kiejna 2018; Liljedahl and Westling 2014; Linehan et al. 2006; Silverman 2006 as cited in Andover et al. 2012).

Within Thai literature, terms referring to suicidal acts with a non-fatal outcome are "attempted suicides", "parasuicides", and "acts of deliberate self-harm" (Disayavanish and Disayavanish 2007: 1682). Unlike completed suicide, non-lethal suicide attempts include the following characteristics: 1) self-initiated self-injurious behaviour; 2) with the intent to die; and 3) a non-fatal outcome (Apter 2010). Within the Thai context, most DSH acts are suicide attempts with a non-fatal outcome committed impulsively or without prior planning, as is exemplified by individuals who intentionally self-poison with household products often contacting someone to inform them that they had committed the act. Deliberate poisoning accounted for 22,175 hospitalisations in 2010, or 89% of those involving DSH in Thailand (Disayavanish and Disayavanish 2007; Lotrakul 2006; Paholpak et al. 2012). As such, suicide-related behaviours and the choice of terms relevant to the present study are DSH and non-lethal suicide attempts.

Using the Scale for Suicidal Ideation, Rungsang et al. (2017) assessed the magnitude of suicidal ideation and its effect on Thai adolescents attending secondary schools. The study found that stressful events have the most substantial direct effect on suicidal ideation, while negative psychological behaviours were the weakest (Rungsang et al. 2017). Similarly, studies conducted in the U.S. have empirically and theoretically linked stressful life events to risks of self-harm in the form of suicidal ideation and behaviour (Liu and Miller 2014; Mann et al. 2005, as cited in Liu et al. 2016). Methods of coping with perceived stressful events consist of externalising behaviours, such as substance abuse, which were commonly reported among males, and internalising behaviours, such as self-harm, among females (Endler and Parker 1990; Matud 2004; Menon et al. 2018; Ptacek et al. 1994 as cited in Kelly et al. 2008; Smith 2016; Whitlock et al. 2015a; Zickler 2000). Furthermore, among both sexes, an increase in stress levels was positively correlated with the possibility of self-harm behaviours, and individuals who engage in those acts do so as a way to ease the perceived intolerable physiological arousal caused by stressful life events (Hack and Martin 2018; Menon et al. 2018).

Although DSH is an act with a non-fatal outcome, it has been reported to be a significant predictor of eventual suicide, with the underlying suicidal motivation of the individual varying considerably (Bird and Faulkner 2000; Cooper et al. 2005 as cited in Menon et al. 2018; Jans et al. 2012; Sarkar et al. 2006; Soomro and Kakhi 2015). A study conducted by Olfson et al. (2017) in the U.S. using a national cohort of adults (N = 61,297) who had been diagnosed with DSH found 89.5% of those who used nonviolent methods of self-harm, such as poisoning and cutting, to have repeated the behaviour within 365 days, with 73.3% ultimately committing suicide within the same time frame. Hawton et al. (2003) conducted a similar study in the U.K. and found the risk of suicide to be the highest in the initial periods following DSH and reported continuing risk years after the event with 1.7% after five years, 2.4% after ten years and 3% after fifteen years. Thus, risks of suicide following acts of DSH are evident.

Patients who are more likely to attempt suicide frequently self-mutilate, as evidenced by the thirty-fold increase in the risk of suicide attempts that have been reported when comparing the risks to self-harmers with non-self-harmers (Alper and Peterson 2001; Cooper et al. 2005 as cited in Mangnall and Yurkovich 2008; Cuellar and Curry 2007). However, Whitlock et al. (2015b) disregarded self-harm as a predictor of future suicide attempts as the expressed intent, level of damage, lethality of the method used, and psychological distress of those who engaged in self-harm and attempted suicide differ drastically. The intention of an individual's engagement in self-harm as a coping strategy

is explained by the pain inflicted, which releases emotional distress and asserts feelings of control, whereas suicide is committed to ending feelings altogether (Australian Human Rights Commission 2014; The National Self Harm Network 2008; Whitlock et al. 2015a).

In most acts of self-harm, the damage is inflicted on the body's surface. At the same time, suicide-related behaviours are done with lethal means such as hanging and ingestion of agricultural pesticides, which are the two most common methods among Thais (Grandclerc et al. 2016; Lotrakul 2005, 2006; Whitlock et al. 2015a). The psychological distress experienced by those who engage in acts of self-harm has been reported to be significantly lower when compared to those with suicidal tendencies, and, in certain instances, the act of self-harm is committed as a way of avoiding a suicide attempt as it lowers the inhibition of suicidal thoughts through the habituation of pain infliction (Australian Human Rights Commission 2014; Whitlock et al. 2013; Whitlock et al. 2015a). Nevertheless, the consensus of the arguments within the western literature does not diminish the link between self-harm and suicide, as evidenced by repetitive self-harmers becoming suicidal (Morey et al. 2011). Unlike Thai literature, acts of DSH are often classified within the western literature as non-representative of the individual's desire to die, but rather a "morbid form of self-help" and a "functional alternative to suicide" (Disayavanish and Disayavanish 2007; Morey et al. 2011: 2).

Cultural Dimensions

From one culture to another, the conceptualisation of mental illness varies as what is considered an abnormality depends on the cultural context (Butcher et al. 1993; Choudhry et al. 2016). Cultural stereotypes, personal knowledge, and the proximity of personal interactions with the mentally ill lay the foundation of the general public's beliefs and attitudes. Cultural context is significant when studying the public's understanding of mental health (Choudhry et al. 2016). Suicide in certain cultures, such as Japan, is often perceived as an honourable act, potentially an atonement, as Japanese culture places a high value on group cohesiveness, whereby exclusion from the group is perceived as intolerable (Takahashi et al. 1998). Among Asian Pacific Islanders, the general view of the cause of mental illness is believed to stem from family conflicts. At the same time, a majority of Southeast Asians perceive supernatural aspects to be responsible. Within the Jewish population, mental illness is seen as a religious opportunity for believers to gain forgiveness, improve their souls and receive divine messages (Douglas and Fujimoto 1995; Selekman and Zavadivker 2021).

Acts of suicide among Thais are seen as selfish and commonly committed as an escape from guilt or financial debt (Lotrakul 2006). Studies indicate that the motive which leads an individual to commit suicide is often dependent on a society's fundamental cultural values (Kumar et al. 2017). A vast majority of the Thai population is influenced by the teachings of Buddhism (Disayavanish and Disayavanish 2007). The act of suicide is seen as a direct violation of the first of five precepts, the killing of living beings, and the only way for a human to cease suffering is through nirvana. Moreover, the "Four Noble Truths", which is the heart of the Buddha's teachings, defined the act of suicide as a form of suffering that arises from the craving for destruction; human beings thereby cannot escape "the wheel of suffering" nor avoid it by committing suicide as the consequence of taking one's own life is rebirth into endless suffering, known as the "woeful planes of existence" (Disayavanish and Disayavanish 2007: 1680).

How individuals perceive and manage their everyday stressors is influenced by their respective cultural dynamics (Callister 2003; Satcher 2001, as cited in Subudhi 2015). Satcher (2001) reported that African Americans gravitate towards active approaches when facing personal problems rather than avoiding them, whereas Asian Americans tend towards inhibition and avoidance coping frameworks. Within the majority Buddhist Thai population, religion encourages emotional restraint, social inhibition, and self-control (Satcher 2001). McCarty et al. found that when compared to American children, Thai children were two times more likely to opt for covert coping methods such as "not talking back", while American children opt for overt coping methods such as "running away" and "screaming" (1999: 812). Weisz et al. (1993) found that as aggression is discouraged among Thais and inhibition is encouraged, Thai adolescents exhibited problems such as compulsivity, using indirect methods of coping such as sulking and sullenness. Culture has implications for implementing coping styles, influencing the level and severity of mental health problems due to individual differences (McCarty et al. 1999; Satcher 2001).

Psychologically, pain perception is reflected in the emotional responses of the individuals. Chronic pain sufferers have been reported to be even more terrified of pain than death itself (Mongkhonthawornchai et al. 2013). Studies indicate that Thais perceive pain as an intense and oppressive burden that often results in crying and begging for relief. Most of the participants in Mongkhonthawornchai et al. (2013) reported that they would prefer to die so that the pain would go away. Thus, culture influences the formation of an individual's response patterns regarding the expression of pain (Lovering

2006). This may be one explanation for the prevalence of DSH among Thais, which often leads to suicide attempts.

Public Perceptions

Regional studies revealed variances in the public's perception of self-harm. For example, in assessing teacher perceptions of NSSI among students, a British study found that adverse affective reactions were expressed towards self-harm, such as being "repulsed" and "shocked" (Best 2005; Best 2006 as cited in Heath et al. 2011: 36). Another study conducted in Nottingham presented 335 adult participants with vignettes and assessed the perceived motivations for self-harm and their inclination to help and reject responses of the general public by asking respondents to complete self-reported questionnaires as adopted from the Corrigan et al. (2003) attribution model of public discrimination (Nielsen and Townsend 2018). The study found an increased endorsement of responsive helping when the perceived suicidal intent of the vignette was high; however, the study only assessed intentions rather than actually helping and rejecting behaviour (Nielsen and Townsend 2018).

A study conducted in New Zealand explored the Pasifika people's understanding of DSH and found that many of the participants saw the behaviours to be "a cry for help", indicating that harming oneself is used as "bait" to obtain sympathy while others perceived the acts as a way of diminishing emotional numbness (Dash et al. 2017: 120). However, the study included only 20 participants. Exploring the perceptions of suicide in a New Zealand university, Curtis (2010) found the willingness of the participants to help others in need to be higher than the willingness to seek help for themselves due to stigmas surrounding help-seeking.

Thai Perceptions

Previous studies within the Thai context regarding public perceptions focus on completed suicide rather than acts of DSH and failed suicide. Chaniang et al. (2019) conducted a qualitative descriptive study on the perceptions of adolescents, teachers, and parents in Chiang Mai towards suicide and found that school achievement expectations were perceived to be a significant indicator of adolescent suicide by both the parents and teachers alike (Chaniang et al. 2019). Interestingly, romantic relationships were mentioned to be an issue that leads to adolescent suicide, stating that "adolescents who fall in love at school tend to seek attention by cutting themselves on their arms or wrists",

which indicates acts of DSH are seen as suicide-related behaviour (Chaniang et al. 2019: 52). On the other hand, the adolescents reported inadequate social and familial support led to feelings of loneliness which becomes a stressor, causing suicidal tendencies (Chaniang et al. 2019). Although the Chaniang et al. (2019) study provides insight into Thai perception, the findings cannot be generalised as the study only drew its participants from a secondary school in an urban area of Chiang Mai. A study by Fellmeth et al. (2015) explored the perceptions of mental illness among pregnant migrants, refugees, and antenatal clinic staff along the Thai-Myanmar border and found that a small number of the participants saw spirits as the perceived cause of mental illness, while shame, family issues, and economic hardships emerged as a significant theme. Moreover, the participants did not attribute suicide to the manifestation of mental illness (Fellmeth et al. 2015).

Being a "poorly understood" phenomenon, individuals who self-harm are often ascribed blame, whereby the general public often attributes a sense of perceived controllability of the individual towards their harmful behaviour (Royal College of Psychiatrists 2010 as cited in Nielsen and Townsend 2018: 2). Pitakchinnapong and Rhein (2019) reported that, in general, Thais perceive people with mental illnesses to be faking their condition for attention and suicide which is often seen as a foolish act committed by the weak, bringing about mockery and insults. Additionally, psychological disorders are perceived as issues with an individual's personality, which are believed to be permanent even if help is sought out (Pitakchinnapong and Rhein 2019). Those who have harmed themselves in the past are seen as violent and dangerous to the community, neighbours are scared and disgusted by them, and the families of the mentally ill feel ashamed to be associated with them (Pitakchinnapong and Rhein 2019). The same study reported that the seven most common Thai myths about the mentally ill are: 1) the mentally ill are violent and dangerous (72.88%); 2) the mentally ill are not like normal people (67.79%); 3) the mentally ill should be held responsible for their illness (59.32%); 4) the mentally ill are lazy and lack enthusiasm (49.15%); 5) the mentally ill are stupid, lacking cleverness (42.37%); 6) the mentally ill cannot be good members of society (37.29%); and 7) the mentally ill cannot change and become normal (25.42%). These findings indicate the general public's lack of compassion and understanding towards those with mental illness.

A standard limitation of the existing literature lies within the rather focused range of participants; most are not accurate representations of the general population of their respective countries. Studies focus on limited subpopulations such as secondary schools, university students, teachers, and parents. As a result, almost all previous research findings do not represent

the general public and cannot be used in large-scale comparisons between countries. In addition, the existing literature emphasises the general public's perception of NSSI and completed suicide as opposed to acts of DSH and failed suicide. With the majority of DSH in the context of Thailand being committed impulsively with suicidal intent, the existing literature on the topic is insufficient (Lotrakul 2006). The present study addresses this gap in the existing literature by examining the Thai general public's perceptions of DSH with suicidal intent based on impulsivity.

METHODOLOGY

Based on a pilot study in 2019, the present study builds upon existing literature by applying Nielsen and Townsend's (2018) work on public perceptions of self-harm which adopted the Corrigan et al. (2003) attribution model of public discrimination towards persons with mental illness questionnaire to explore the perceptions and attributions of the general Thai population in response to acts of DSH. One hundred twenty-seven participants took part in this study. Participants ranged in age from 17 to 63 years (M = 34.24, SD = 15.03). Age was non-normally distributed, with skewness of 0.49 (SE = 0.19) and kurtosis of –1.347 (SE = 0.37). One participant did not indicate their age. The sample included 65 females (51.2%), 61 males (48.0%), and one unspecified (0.8%), which was removed from the analysis due to the inability of gender comparison. Participants were self-selected after responding to a questionnaire posted on Facebook, Line, Twitter, Discord, and Twitch social networking sites. Data were collected through the online questionnaire. In addition, participants were presented with two vignettes based on an excerpt from interviews in the study, "Attempted suicide triggers in Thai adolescent perspectives", conducted by Sukhawaha et al. (2016).

The questionnaire has five sections. The first section of the questionnaire is the consent form, where participants were asked to either "Agree" or "Disagree" to complete the procedure. The second section asks the participants to answer demographic questions about themselves: age and gender. Sections 3 and 5 were direct adaptations of the attribution model of public discrimination (Corrigan et al. 2003). For example, within section 3, the term "mental illness" which is present in Corrigan et al. (2003), was changed to "deliberate self-harm" as the section assesses the participants' familiarity with the phenomenon (e.g., "My job involves providing services/ treatment for persons who commit acts of deliberate self-harm").

Section 4 comprises two vignettes, one based on a fictional male named "Ice" who overdoses on pills and the other based on a fictional female named "Noey" who ingests poisons. Participants were asked to read both and select which case they would like to respond to. The selection of a male and female vignette was required, and only after the participants had chosen their respective vignette did the rest of the questionnaire appear.

Female Vignette

The first case vignette depicted a 17-year-old female, Noey, with an unwanted pregnancy who had deliberately ingested a bathroom cleaner as a method of self-harm:

"When my boyfriend, who was the father of my child, left me, I had no way out. I wanted to get away from the problems. I felt worthless. I pitied myself for all my suffering. I didn't want the baby, didn't want to live. So I walked to the bathroom. I noticed the bathroom cleaner there and the thought popped into my head that it'd be better for me to be gone, so I drank it".

Male Vignette

The second vignette depicted a 17-year-old male, Ice, who deliberately ingested pills as a method of self-harm after a fight with his father:

"Dad had just bought me a new phone. After only one day, I dropped it and the screen broke. I felt very angry with myself. I went to my room, punched the walls and broke everything. At night, my headache was so bad it caused me to be sleepless. It was hell. And I was still angry with myself so I thought about what I could do to get rid of the pain as quickly as possible. I was tired of myself. I saw several packets of medicine which my dad had just gotten from the hospital in a bag, so I took every pill in the bag ... 27 pills in total".

The vignettes chosen are in a first-person nature which is different from the commonly employed third-person perspective. This is said to have a more "ecologically valid description" regarding the information about the act of DSH (Nielsen and Townsend 2018: 5). No information regarding a psychiatric diagnosis was provided within the vignette, as acts of DSH can be committed by those without mental illness. This omission was based on the intention to avoid the attribution of stigmas surrounding mental illness, suicidality, and DSH (Morey et al. 2011; Carpiniello and Pinna 2017; Scanlan and Purcell 2010). The demographic characteristics and method of DSH depicted in the case vignettes were guided by existing literature and chosen

to represent common cases involving DSH in Thailand (Paholpak et al. 2012; Sukhawaha et al. 2016).

Section 5 comprised the Corrigan et al. (2003) questionnaire, which assesses PRB (e.g., "I would think that it was Noey's own fault that she is in the present condition"), affective responses including pity (e.g., "I would feel pity for Noey"), anger (e.g., "I would feel aggravated by Noey") and fear (e.g., "How dangerous would you feel Noey is?"), helping responses (e.g., "If I were an employer, I would interview Noey for a job") and rejecting responses of coercion-segregation (e.g., "I think Noey poses a risk to her neighbours unless she is hospitalised"). The hypothetical names of the male and female in the vignettes were changed from "Harry" in the Corrigan et al. (2003) study into common Thai nicknames of "Noey" for female and "Ice" for male so as to ensure that the participants knew which sex they were responding to. Unlike the Corrigan et al. (2003) questionnaire, the headings that separate each subsection (e.g., PRB, pity, and anger) were removed from the questionnaire of the present study to avoid response bias. All questions within section 5 were coded on a nine-point Likert scale (e.g., 1 = not at all to 9 = very much) following Corrigan et al. (2003). At the end of the questionnaire, participants were invited to make additional comments. A total of 18 participants left comments regarding the case vignettes. These comments are analysed in the qualitative data section of this article.

Random online intercept sampling was chosen to avoid researcher bias in selecting participants, as the sampling method relies solely on the will of social networking site visitors. Thus, there was no active recruitment of participants. In each invitation to participate in the questionnaire, a content warning was written in the post's description ("CW: attempted suicide, overdose, deliberate self-harm") to prevent undesirable physical and/or mental reactions. Due to the sensitivity of the research topic, a referral to a counsellor was prompted if needed. Zero participants have requested a referral within the present study. A consent form was placed in the questionnaire's first section, and all participants were required to agree before proceeding with the procedure. The anonymity of the respondents is maintained as the respondent's age and gender are the only identifiers known to the researcher.

RESULTS

The current mixed methods study results are divided into two sections: quantitative and qualitative data analysis, respectively. For the quantitative data, SPSS was used to conduct the statistical analysis. In addition, 126

completed questionnaires were completed online. The reliability of the current study was tested using Cronbach's alpha. The overall value of Cronbach's alpha for the current study was α = 0.71 (95% CI [0.64, 0.78)], which is considered to be within the "good" range (Taber 2017: 1278). Independent sample *t*-tests were conducted to examine gender differences across Thai men and women in their attribution of: 1) PRB; 2) pity; 3) anger; 4) fear; 5) helping; and 6) coercion-segregation, toward persons who committed acts of DSH.

Assessments of Thai Women's Attributions

An independent sample *t*-test examined the differences in Thai women's attribution of: 1) PRB; 2) pity; 3) anger; 4) fear; 5) helping; and 6) coercion-segregation towards the two clinical case vignettes presented within the questionnaire. Under Section 5.1.1 Female Respondent's Attributions, each attribution section (i.e., pity, anger, fear) will be analysed individually. The context of the analysis is as seen in Tables 1 and 2.

Table 1: Group statistics of Thai women's attributions

VIN		N	Mean	Std. deviation	Std. error mean
PRB	1	42	5.27	1.82	0.28
	2	23	4.94	1.92	0.40
PITY	1	42	6.95	1.67	0.26
	2	23	6.35	2.07	0.43
ANGER	1	42	4.10	2.20	0.34
	2	23	4.71	2.04	0.43
FEAR	1	42	3.72	2.43	0.38
	2	23	5.01	2.51	0.52
HELPING	1	42	5.71	1.69	0.26
	2	23	4.16	1.31	0.27
CS	1	42	3.73	2.17	0.33
	2	23	4.88	2.11	0.44

Notes: PRB = personal responsibility beliefs, CS = coercion-segregation, VIN = vignette.

Table 1 presents the group statistics for Thai women's attributions for different factors, including PRB, pity, anger, fear, helping, and coercion-segregation. The table shows the mean, standard deviation, and standard error of the mean for each group. The data suggest that on average, the female respondents had a higher score for pity and helping for vignette 1, while response to vignette 2 indicate higher scores for fear and coercion-segregation.

Table 2 presents the results of the independent samples *t*-test for Thai women's attributions. The table includes Levene's test for equality of variances and the *t*-test for equality of means. The data suggest that there were significant differences between the two groups for fear, helping, and coercion-segregation, with women, when responding to vignette 2 having higher scores on these attributes. There were no significant differences between the two groups for PRB, pity, and anger.

Table 2: Independent samples *t*-test of Thai women's attributions

		Levene's test for equality of variances		*t*-test for equality of means						
		F	Sig.	*t*	df	Sig. (2-tailed)	Mean difference	Std. error difference	95% confidence interval of the difference	
									Lower	Upper
PRB	Equal variances assumed	0.190	0.661	0.68	63	0.498	0.33	0.48	–0.63	1.29
PITY	Equal variances assumed	0.840	0.362	1.28	63	0.205	0.60	0.47	–0.34	1.55
ANGER	Equal variances assumed	0.220	0.639	–1.09	63	0.279	–0.61	0.56	–1.72	0.50
FEAR	Equal variances assumed	0.010	0.934	–2.03	63	0.047	–1.29	0.64	–2.57	–0.02
HELPING	Equal variances assumed	1.620	0.208	3.81	63	0.000	1.55	0.41	0.73	2.36
CS	Equal variances assumed	0.008	0.930	–2.07	63	0.043	–1.15	0.56	–2.27	–0.04

Notes: PRB = personal responsibility beliefs, CS = coercion-segregation.

Overall Attribution of Thai Women Respondents

The preliminary analysis concludes that under the section of "fear", "helping", and "coercion-segregation", a significant difference was detected. In contrast, other non-significant differences were detected for sections "personal responsibility beliefs", "pity", and "anger".

Assessments of Thai Men's Attributions

An independent sample *t*-test was conducted to examine the differences in Thai men's attribution of: 1) PRB; 2) pity; 3) anger; 4) fear; 5) helping; and 6) coercion-segregation towards the two clinical case vignettes presented within the questionnaire. Under Section 5.1.2 Male Respondent's Attributions, each section of attribution (i.e., pity, anger, fear) will be analysed individually. The context of the analysis is seen in Tables 3 and 4.

Table 3: Group statistics of Thai men's attributions

VIN		N	Mean	Std. deviation	Std. error mean
PRB	1	39	4.92	1.61	0.26
	2	22	5.03	2.30	0.49
PITY	1	39	6.53	1.89	0.30
	2	22	5.98	2.27	0.48
ANGER	1	39	4.03	1.67	0.27
	2	22	5.30	2.44	0.52
FEAR	1	39	4.33	2.33	0.37
	2	22	6.20	2.20	0.47
HELPING	1	39	5.79	1.95	0.31
	2	22	3.83	1.44	0.31
CS	1	39	4.14	1.91	0.31
	2	22	4.58	2.01	0.43

Notes: PRB = personal responsibility beliefs, CS = coercion-segregation, VIN = vignette.

Table 4: Independent samples *t*-test of Thai men's attributions

		Levene's test for equality of variances		*t*-test for equality of means						
		F	Sig.	*t*	df	Sig. (2-tailed)	Mean difference	Std. error difference	95% confidence interval of the difference	
									Lower	Upper
PRB	Equal variances assumed	3.69	0.060	–0.21	59.00	0.831	–0.11	0.52	–1.11	0.90
PITY	Equal variances assumed	0.86	0.358	1.00	59.00	0.320	0.55	0.55	–0.54	1.63
ANGER	Equal variances not assumed			–2.17	32.40	0.037	–1.27	0.59	–2.46	–0.08
FEAR	Equal variances assumed	0.02	0.877	–3.06	59.00	0.003	–1.86	0.61	–3.08	–0.64
HELPING	Equal variances assumed	2.98	0.089	4.11	59.00	0.000	1.95	0.47	1.00	2.90
CS	Equal variances assumed	0.08	0.785	–0.84	59.00	0.400	–0.44	0.52	–1.48	0.60

Notes: PRB = personal responsibility beliefs, CS = coercion-segregation.

Table 3 displays the group statistics of Thai men's attributions for six categories: PRB, pity, anger, fear, helping, and coercion-segregation. The table provides mean, standard deviation, standard error mean, and sample size (N) for each category and subcategory based on two different vignettes (VIN 1 and VIN 2). The mean scores of each category for both vignettes were different for some subcategories. For example, the mean score of pity was higher for VIN 1 compared to VIN 2, while the mean score of fear was higher for VIN 2 compared to VIN 1.

Table 4 provides the results of the independent samples *t*-test for six categories: PRB, pity, anger, fear, helping, and coercion-segregation. The table shows the Levene's test for equality of variances and *t*-test for equality of means for each category. The test compares the means of each category between the two vignettes. The table shows that for anger and fear categories, the variances were not equal, while for the other categories, the variances were assumed to be equal. The *t*-test results showed significant differences in means between the two vignettes for anger, fear, and helping categories, while no significant difference was found for PRB, pity, and coercion-segregation categories.

Overall Attribution of Thai Men Respondents

The preliminary analysis concludes that under the section of "anger", "fear", and "helping", a significant difference was detected. While other non-significant differences were detected for sections "personal responsibility beliefs", "pity", and "coercion-segregation".

QUALITATIVE DATA

At the end of each questionnaire, participants were invited to leave additional comments regarding the chosen vignette. Out of 127 participants, 18 (14%) left comments. To analyse the qualitative data of the present study, themes were identified by analysing the patterns within the comments of the respondents following Creswell to describe the "meaning of the lived experience for several individuals concerning a particular phenomenon" (1998: 51). Therefore, only the comments relevant to the research question of the present study were analysed. As a result, five themes were identified: 1) attribution of blame; 2) willingness to help; 3) anger; 4) perceived dangerousness; and 5) coercion-segregation.

Female Vignette Noey

The first case vignette depicted a 17-year-old female, Noey, with an unwanted pregnancy who had deliberately ingested a bathroom cleaner as a method of self-harm. A total of 11 comments (61%) were included by the participants, comprised of 7 males (64%) and 4 females (36%), ranging in age from 19 to 63 years old. In addition, comments relevant to the present study's research question were selected for analysis. Within the female-based vignette, the following themes emerged: 1) attribution of blame; 2) willingness to help; and 3) coercion-segregation.

Attribution of Blame

As seen in the excerpt below, respondents expressed an attribution of blame. The respondents mentioned that blame would be ascribed depending on the consent of the sexual encounter, which resulted in the unwanted pregnancy. If the pregnancy was non-consensual (i.e., rape), the blame would be put upon the rapist as the cause of the pregnancy and Noey, the person who participated in the act of DSH, as the victim. Otherwise, Noey is to blame for her non-lethal suicide attempt as she participated in premarital sex.

> I strongly disagree with premarital sex, but if her case was non-consensual, it would rather be her boyfriend's fault, not hers. If she did choose to fornicate of her own free will, she should have to live with the consequences. (male, 19 years old)

Willingness to Help

In terms of willingness to help, most respondents regarded their proximity to the person in need to be a significant indicator of whether or not they will offer help. A closeness in proximity ranging from an acquaintance to a friend and a family member received more likeliness in help offerings, while complete strangers were less likely to be offered help.

> My answers would change depending on whether or not I personally knew her, if I did, then some of my responses would be different, I would be more willing to help her. (male, 21 years old)

> Since she is a stranger to me I would not help her, I would only help her if she was my cousin or friend. (female, 36 years old)

Other respondents steered away from offering direct help. One of the respondents mentioned meditation as a treatment for suicidal thoughts and urges, believing that it would alleviate Noey's current state of mind. Less willingness to directly help Noey is shown by respondents, where alternative forms of help were mentioned instead. Respondent comments included:

> I would suggest her to try meditation to clear her mind so that she could think better and find [a] better answer to go forward with her life. (female, 63 years old)

> Noey needs people around her to give her helping hands, convince her for the positive sides to have and bear a baby. (male, 52 years old)

Although the respondents show some compassion, there is a lack of directness in the offering of help by the respondents. Only one respondent showed a high willingness to help Noey. As seen in the excerpt below, the respondent is willing to give Noey an opportunity in means of a job. High compassion is shown here as the respondent offers to "sooth" and "observe" her. In this sense, there is less willingness of the respondent himself to helping Noey.

> I will judge her after I gave her an opportunity, give her a job to sooth her condition and then observe her attitude what is suit[able] for her. (male, 30 years old)

Coercion-segregation

Regarding the coercion-segregation theme, a respondent disagreed with inpatient treatments for Noey, however, the same respondent remarked that group homes may be ideal. The disagreement with inpatient treatments in a psychiatric hospital suggests that there is less perceived dangerousness attributed to Noey. Coercion in terms of mandatory inpatient treatment is lacking. However, the agreement that a group home is suitable for Noey is a form of discriminatory behaviour as it suggests that she should be isolated from her community.

> She should not go to [a] mental hospital [be]cause she is pregnant with a child. It would be best if she gets the help she need[s] to raise her child. She just needs love and consoling from her family or people who are in the same situation as her. I think group home would be good for her. (female, 36 years old)

Male Vignette Ice

The second vignette depicted a 17 years old male, Ice, who deliberately ingested pills as a method of self-harm after a fight with his father. Within this vignette, a total of 7 comments (38%) were made, all males ranging in age from 20 to 47 years old. Again, comments relevant to the present study's research question were selected for analysis. Within this vignette, five themes emerged: 1) attribution of blame; 2) willingness to help; 3) anger; 4) perceived dangerousness; and 5) coercion-segregation.

Attribution of Blame

As seen from the excerpt below, blame is not attributed to Ice by the respondent. A suggestion made by the respondent that his father might be the cause of his condition suggests that attributions about the cause and controllability of his condition is due to external forces (i.e., domestic abuse). The perceived controllability of his condition is seen as lacking, and he is thereby not seen as personally responsible for his current situation as the respondent attributes no PRB.

> His dad might be abusive to him causing him to be this way. (male, 47 years old)

Willingness to Help

Willingness to help is seen as circumstantial. For example, a respondent who mentioned less likeliness to interview Ice for a job indicated he would be "very happy" to act as a landlord for a tenant such as Ice. Attributions can be seen in this response. The presumption that Ice lacks the means to "confront reality" shows that the respondent might attribute a certain extent of mental illness to Ice, seeing him as being out of touch with reality. Yet when faced with another hypothetical situation of being a landlord, help is offered. That prejudice can be seen to lead to discriminatory behaviours under specific circumstances. However, despite the presumption of flawed character, there is still a certain degree of help.

> If I am his employer, I am not likely to interview him because he does not confront reality. Therefore, he is more likely [to] try to hide a problem or solve it alone rather than consult the team to solve it … If

> I am his landlord, I will be very happy to have him because he care[s] about his stuff and likely to try to fix/replace the broken stuff. (male, 20 years old)

Anger

A majority of the respondents attributed aggression to his characteristics. However, no affective response of anger was elicited directly towards Ice. Several respondents mentioned "anger management" as a form of treatment for his condition. However, no mention of an attribution of mental illness was seen. The respondents perceived his destructive behaviour as an issue with emotional self-regulation.

> Ice should calm down and get anger management. (male, 20 years old)

> Ice has anger management issues. (male, 41 years old)

Other respondents perceived a level of abnormality in the situation that Ice was in. The condition was seen as abnormal by a respondent and the situation was seen as abnormal by another. The differences in the attribution of abnormality here is notable. Seeing Ice's behaviour, his condition, as abnormal suggests that the outburst of aggression by Ice is validated as a legitimate response to stress. Help is also suggested by the same respondent, showing a certain level of compassion.

> Ice needs to seek help. It is not normal that he is so angry at himself for something as little as phone screen breaking. (male, 47 years old)

The other respondent who saw an abnormality in the situation that Ice was in suggests that there is an invalidation in the legitimacy of his emotional response by the respondent. The mentioning of another hypothetical situation which would validate his emotional response suggests a lack of compassion by the respondent towards Ice. A level of emotional invalidation was depicted, in which "the respondent rejected Ice's" experience.

> I feel that Ice's father will not [be] angry at Ice because the phone is Ice's phone and not a family phone. However, everyone will be angry if Ice requests a new screen or new phone just 1 day after purchase. (male, 20 years old)

Perceived Dangerousness

The attribution of perceived dangerousness by the respondents to Ice varied drastically. A participant saw the possibility of Ice hurting himself and those around him. However, another respondent disagreed that Ice was a danger to those around him and suggested that he is only a danger to himself. A respondent attributed an association of dangerousness, violence and unpredictability to Ice's character. The suggestion for him to "get help" indicates a desired social distance between the respondent and Ice. Dangerousness in this case has been associated with increased social distance by the respondent as he believes that Ice should not live in an inpatient facility or a group home and should be segregated where he could not hurt others around him.

> He should not live in a group home where he may hurt other people. He poses a danger to himself and possibly to others around him. He needs to get help. (male, 41 years old)

Another respondent disagreed and did not see Ice to be dangerous to others around him as Ice was seen as a threat only to himself. The disagreement in the perception of dangerousness is a key indicator of behavioural responses due to the differences in the respondents' attitudes. The attribution of negative and unexpected behaviours, although present in both of the respondents' comments, the difference lies between the desired social distance.

> Ice is a danger to himself but not to others. (male, 39 years old)

Another respondent disagreed and commented that a group home is ideal for Ice's current situation and condition, it can be said that less dangerousness has been attributed to Ice. More compassion is observed within the respondent's comment. As seen below, there is a mention of "friends" who can "listen to his problems". Although putting Ice in a group home is a form of segregation, less attribution of perceived dangerousness is seen. Thinking that Ice could benefit from having others around him shows that the respondent does not believe that Ice should be entirely coerced into segregation from society as a whole.

> Group home is a good solution so Ice can have some friends to listen to his problem. (male, 20 years old)

DISCUSSION

The current study explored Thai attributions of PRB, affective responses, and their inclination to help and reject persons who deliberately harm themselves intending to die. In contrast to existing research, the current study manipulated the presentation format to explore the potential differences in responding to a male and a female text-based vignette. Results showed apparent differences between the vignette conditions in the attributions of anger, help offering, and coercion-segregation. Significant differences were detected in Thai women's responses regardless of the chosen vignette in helping and coercion-segregation. On the other hand, significant differences detected in Thai men's responses were in helping and anger. This indicates that the presence of gender-based stereotypes of those with mental illness exists in Thailand. The stigmatisation of the male as dangerous or aggressive and the female as pitiful or in need of greater help is apparent from the results.

The gender-based response from participants further suggests that the propensity of Thai men and women to offer help varied considerably with the differing vignettes. Thai men and women were more willing to help the female character, Noey. Interestingly, Thai women attributed more personal responsibility than Thai men to Noey when compared to Ice. Contradictory to existing research, although more blame was attributed to Noey by Thai women, they were more likely to help her. Nielsen and Townsend's (2018) results showed that the attribution of PRB led to a decrease in helping responses, suggesting that when more blame is attributed to the individual who self-harms, the less the public is likely to offer help. The inconsistent results may be due to the differences in the implicit emotional rules of display in a collectivistic culture such as Thailand, versus an individualistic culture which Nielsen and Townsend's (2018) study was based in (Laudlai et al. 2018).

Studying the Big Five personality inventory, Buehler et al. (2019) found that Thai women scored highly in neuroticism. As Thai women are more emotionally expressive when compared to men, the higher attribution of blame may be explained by the socially acceptable levels of emotional display (Chaplin 2015; Parkins 2012). Although Thai women blamed Noey for her present condition, more compassion was shown, as evident by the higher scores of helping and an inclination to offer help. Prajayyothin and Dhampraha (1996) reported that Thais see the importance of understanding and kindliness from outsiders and families in situations involving unwanted

pregnancies, whereby the pregnancy should be carried to term. Terminating unwanted pregnancies is considered a crime and a sin within the Buddhist religious principles. This might explain why help would be offered despite the attribution of PRB (Rauyajin 1979; Prajayyothin and Dhampraha 1996; United Nations Population Fund Thailand Country Office and Office of the National Economic and Social Development Board 2013).

Significant differences detected from the coercion-segregation section were found in Thai women's desire for social distance from the character in the male vignette Ice. As hypothesised, increased appraisal of dangerousness led to lower helping, this proved to be particularly true for the case of Ice. In line with Corrigan et al. (2003), the current study's findings indicate increased perceived dangerousness to be associated with an increase in the desire for coercion-segregation; danger is thereby a critical factor in fearful reactions leading to desired social distancing. Coercive treatments, avoidance and withholding of help were predominantly observed in the case of Ice, the attribution model of discrimination suggests that persons who are deemed dangerous are more likely to receive rejecting behaviours (Corrigan et al. 2003). Rungreangkulkij et al. (2019) found that during stressful events, Thai men often react with anger and impulsivity, while Thai women have better coping mechanisms. Perceiving Ice to be dangerous may align with the stereotype that Thai men lack self-control.

The significant relationships observed among the participant's decision to help Noey and reject Ice further highlight the importance of understanding the public perceptions of self-harm. Increased appraisal of anger was associated with a reduced propensity to help. Participants were more likely to help Noey as her self-harm was interpersonally motivated rather than driven by guilt, as is the case with Ice whose DSH was a form of self-punishment, where participants were more likely to advocate for rejecting behaviours evident by the high scores in coercion-segregation. Previous research has noted the perceived functionality of the self-harm act as a determining factor in the public's attitudes (Knowles et al. 2013).

The results further indicate compassion as an important factor influencing public perception and response to persons who deliberately self-harm. Although the overall results of the current study indicated largely tolerant attitudes, the between-group differences detected a need for psycho-education due to the complexity of the multifaceted nature of DSH. Across the sample, the endorsement of coercive-segregation approaches was significantly higher in the case of Ice. Self-harm functions as a means to cope with distressing

situations, interpersonally motivated as in Noey's case or intrapersonally as in Ice. Therefore, the act of self-harm should not be dismissed as ingenuine or not worthy of help (Knowles et al. 2013). The result of the current study indicates the Corrigan et al. (2003) public discrimination model to be a sound theoretical framework for studying public perceptions of DSH. Considerations of the implication of cultural dimensions is a significant factor to consider when studying the public's perceptions. The current study explores the potential influence of gender/sex roles on explicit affective expressions and DSH. The public perception of those who partake in acts of DSH is critical to their help-seeking behaviours, as McMahon et al. (2014) reported. Most people who self-harm do not seek clinical help due to the stigma surrounding the behaviour. The divulgence into the exploration of public perceptions and attributions is a step forward in decreasing the stigma.

LIMITATIONS

There are limitations of the current study. First, the questionnaire used in the current study was conducted entirely in English. Therefore, the results of the current study cannot be generalised to the Thai population, as only Thais who could read and understand English fluently could answer the questionnaire. Furthermore, due to the current study being based solely on a questionnaire, the researcher could not delve further into the qualitative analysis. Therefore, it is advised that future researchers conduct interviews and translate all questionnaires in Thai in addition to the distribution of the other quantitative instruments, which may allow for further insight into the public's perceptions.

CONCLUSION

Despite the limitations faced, the findings from the current study offer novel insights and evidence of the attribution process in regards to discrimination and response intentions of Thais toward DSH as a tool of impulsive suicide attempts. The exploration of the varying attributions of self-harm by the general public is crucial as it may directly influence help-offering and rejecting behaviours (Knowles et al. 2013). The results of the current study highlight the vital need for public awareness and education programmes. Although public understanding of the complexity of self-harm is crucial (McDougall et al. 2010), initial reactions are critical to the subsequent disclosures and

help-seeking among self-harmers. The creation of educational materials that reduce the stigmatisation of mental health issues and allow for greater open communication would lend to creating a more open environment for the discussion of DSH.

COMPLIANCE WITH ETHICAL STANDARDS

This research was conducted following ethical guidelines as stipulated in the Collaborative Institutional Training Initiative (CITI Programme) ethics protocols.

NOTES

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